Technical Assistance Manual

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List of Acronyms

ACDP - AIDS Community Demonstration Project

AED - Academy for Educational Development

APA – American Psychological Association

ASO - AIDS Service Organization

BSSV - Behavioral and Social Science Volunteer

CBO - Community-Based Organization

CDC – Centers for Disease Control and Prevention

CID - Community Identification Process

CPG - Community Planning Group

DEBI - Diffusion of Effective Behavioral Interventions

HIV – Human Immunodeficiency Virus

IDU – Injection Drug Users

MOA - Memorandum of Agreement

MSM – Men Who Have Sex With Men

NGI – Not Gay Identified

PROMISE – Peers Reaching Out and Modeling Intervention Strategies

PTC - Prevention Training Centers

RMS – Role Model Stories

SOW - Scope of Work

STD – Sexually Transmitted Disease

TA - Technical Assistance

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How to Use This Manual

This Technical Assistance Manual was developed as a resource for organizations that provide technical assistance (TA) to agencies that implement the Community PROMISE (Peers Reaching Out and Modeling Intervention Strategies) intervention. The manual provides a review of key information regarding Community PROMISE, such as the core elements and implementation tasks, and addresses common questions that agencies may have about planning for and carrying out the intervention.

Intended Audience
This manual is intended to be a tool for TA providers who are helping agencies implement Community PROMISE effectively, appropriately, and with fidelity to the core elements. Among the main TA providers for the Community PROMISE intervention are the American Psychological Association's (APA) Behavioral and Social Science Volunteers (BSSV). The BSSVs have expertise in providing TA to organizations working with programs that provide sexually transmitted disease (STD) and HIV services, and they have been trained on Community PROMISE. In addition, many expert Community PROMISE trainers and implementers can, as necessary, provide valuable guidance on the intervention. Further discussion on TA for Community PROMISE, including how to request and obtain TA, is contained in Section Two: Technical Assistance for Comminuty PROMISE.

TA providers can use the manual to respond to specific questions posed by the implementing agency, or as a guide in providing a proactive assessment of and response to overall TA needs.

Although the manual is geared toward TA providers, it can also be a valuable resource for agencies as a reference during their planning and implementation process. Agencies may use the manual to supplement information provided in the Community PROMISE trainings. However, the manual is most effective when combined with assistance by TA providers.

Content
This manual has four sections. Section One introduces the manual and discusses the Community PROMISE training program. Section Two reviews the basics of TA, and discusses why and how agencies can access and benefit from TA on Community PROMISE. Section Three provides a brief review of the intervention's core elements and implementation tasks.

Section Four contains the heart of the TA manual. Divided into seven topic areas, this section responds to common questions regarding planning and implementing the intervention. Those topics include: decision-making and getting started, conducting the community identification (CID) process, recruiting and training peer advocates, developing role model stories, distributing role model stories and risk reduction materials, evaluating the intervention, and managing and sustaining the intervention.

Each of the seven topics is introduced by a brief description of the key issues related to that topic that may require TA. A series of relevant questions and answers that agencies might pose follows the description.

A resource appendix at the end of the manual provides references to important supplementary materials on Community PROMISE and TA.

Section One: Introduction

Background on Community PROMISE Training and TA

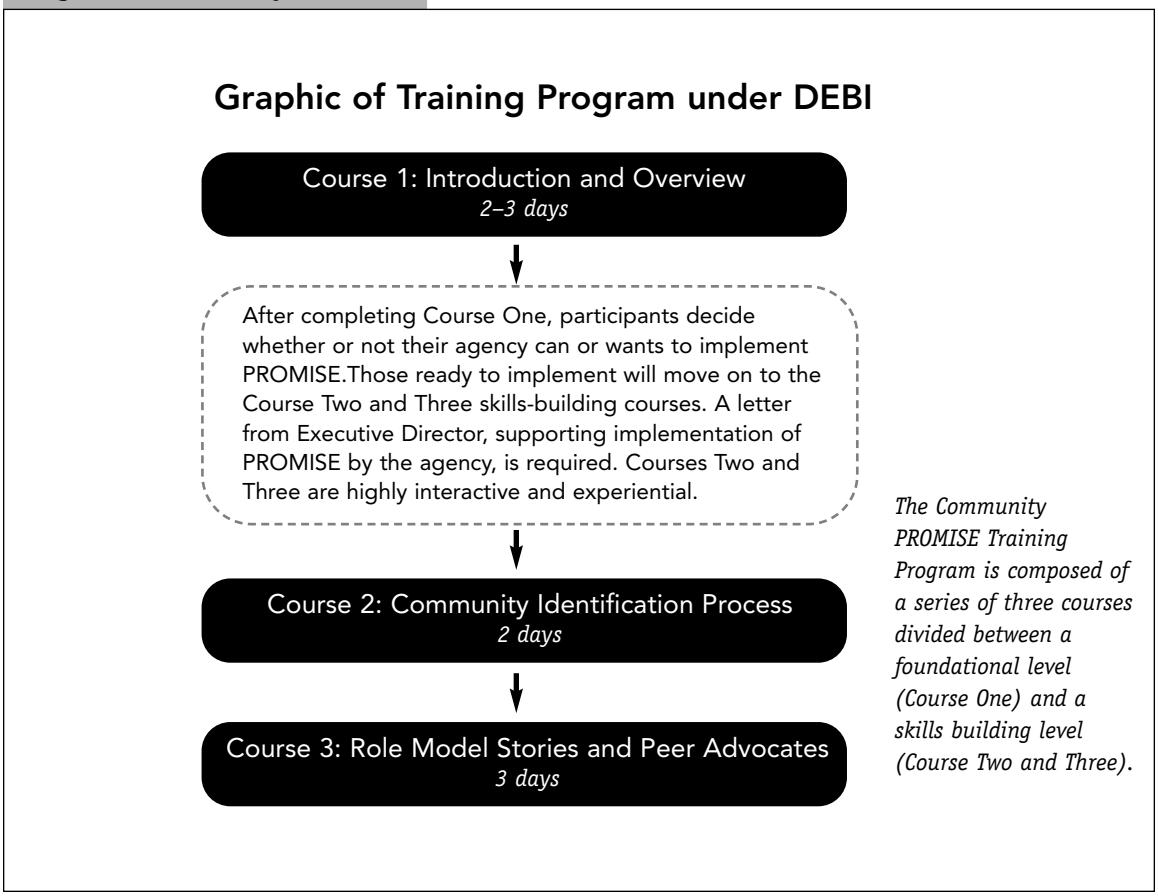
Community PROMISE is a science-based, community-level STD/HIV prevention intervention. Created by and for the community, this intervention is centered around personal stories of positive behavior change, and uses peers from the target population to distribute the printed stories and other prevention materials. The intervention is described in greater detail in Section Three: Review of Community PROMISE: Core Elements and Implementation Steps.

Community PROMISE is one of the effective interventions being nationally diffused by the Centers for Disease Control and Prevention (CDC), with assistance from the Academy for Educational Development (AED), the Prevention Training Centers (PTC), and the intervention's developers and original researchers. The CDC-funded Diffusion of Effective Behavioral Interventions (DEBI) project aims to develop and coordinate a national-level strategy to provide high-quality training and TA on science-based, community- and group-level STD/HIV interventions to state- and community-level STD/HIV programs. The project strives to get STD/HIV prevention interventions into the hands of organizations that need them most in order to address STD/HIV and related issues in their communities. For more information on DEBI, visit www.effectiveinterventions.org.

Under the DEBI project, community-based organizations (CBOs) and other agencies with a need and capacity to implement Community PROMISE can receive training on the intervention. The Community PROMISE training program is composed of a series of three courses -- one foundational and two skills-based. The first course provides a comprehensive overview of the core elements and the steps for implementing and managing the intervention. This course enables participants to assess whether or not the intervention is appropriate for their organization and community. If Community PROMISE is a good fit, participants can move on to the two skills-based courses on the Community Identification Process and Role Model Stories and Peer Advocates. These two courses help participants develop the knowledge and skills necessary to carry out the core elements of Community PROMISE. Through interactive training activities and field-based work, participants are given the

tools to make Community PROMISE happen in their community. Another important tool for participants in the training is the Community PROMISE Implementation Manual, which provides a description of the intervention and its core elements, a step-by-step description of all the Community PROMISE intervention components, a number of tools to assist in planning and implementing the intervention, and a list of resources. Participants must attend all three courses to fully prepare for implementing Community PROMISE. Figure 1 illustrates the Community PROMISE training program. For more information on attending a training, please call (800) 462-9521, or email interventions@aed.org, or visit www.effectiveinterventions.org.

Figure 1: Community PROMISE



The Community PROMISE Training Program is composed of a series of three courses divided between a foundational level (Course One) and a skills building level (Course Two and Three).

In addition to providing high-quality training, the DEBI project also offers ongoing TA to assist agencies in effectively and appropriately implementing Community PROMISE. A group of highly-skilled TA providers, including those from the BSSV Program, have been trained on Community PROMISE and are available to assist agencies in-person and by phone and email. More information on TA providers and accessing TA is provided in Section Two: Technical Assistance for Community PROMISE.

The Technical Assistance Manual

This manual was developed as a tool for the provision of TA to agencies who are implementing the Community PROMISE intervention. Primarily geared toward TA providers, the manual can also be used by implementing agencies.

This manual was developed from extensive research of over fifteen years of development and implementation experience on Community PROMISE. However, agencies considering implementing Community PROMISE should consider all experiences and examples listed in this manual. They should not assume that what worked in a Community PROMISE demonstration site located geographically close to them will necessarily work for their agency. The content of this manual was drawn from interviews with individuals who are highly experienced in Community PROMISE, the Implementation Manual and other intervention materials, and pilot training sessions and transcripts. The section on "How to use this manual" provides more information on the manual's content and format.

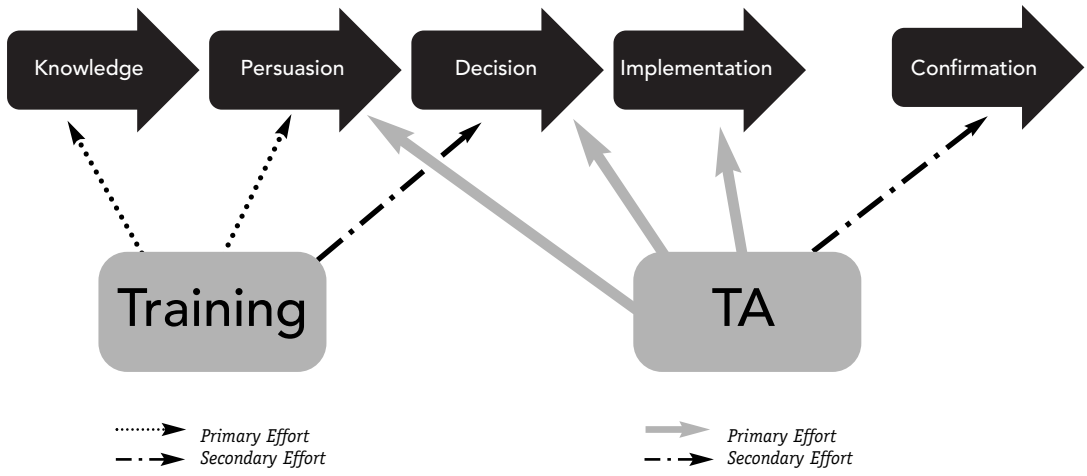
Section Two:
Technical Assistance for Community PROMISE

Understanding Technical Assistance
Technical Assistance is broadly defined as the provision of direct or indirect services designed to increase the capacity of individuals and organizations to carry out programmatic and management responsibilities. In regard to STD/HIV prevention interventions, TA is aimed at assisting organizations to effectively and appropriately prepare for and carry out intervention activities that respond to STD/HIV and related concerns in their target communities.

TA for interventions such as Community PROMISE can include: helping agencies assess their community's needs and assess and develop their agency's human, financial and material resources; develop the agency's level of knowledge and skills to meet their community's needs through programs and services; and evaluate or monitor the outcomes of programs and services. TA is provided by individuals with experience and expertise in relevant technical and programmatic areas, as well as skills in effectively providing assistance. The medium for TA provision can include email, phone, and in-person consultation. TA can be provided reactively, in response to requests by the agency, or proactively, as initiated by the TA provider.

Under the DEBI project, organizations have access to TA to complement and build upon training activities. The aim is to further enable agencies to effectively apply knowledge and skills acquired in training and to appropriately and successfully implement intervention activities. After participating in a DEBI training program such as Community PROMISE, organizations may need support and guidance in areas ranging from deciding whether the intervention is appropriate for the organization's community, to carrying out the intervention itself, to monitoring the outcome of the intervention. The DEBI project is grounded in the theory of Diffusion of Innovation (see the Community PROMISE Implementation Manual, Module 1: Introduction and Core Elements), which identifies TA as an important element for diffusion. As illustrated in Figure 2, TA can be delivered at many points in the diffusion process.

Figure 2: Model of the Diffusion Process



Adapted from Rogers EM. "Diffusion of Innovation," 4th edition, Free Press, *NY, 1995.*

Requesting and Receiving TA for Community PROMISE

Because the Community PROMISE intervention is a complex intervention, the training program is comprehensive in order to properly prepare implementers. However, training participants will likely have questions and concerns about training topics after returning to their agencies and digesting the information. TA is a valuable opportunity to respond to questions and guide agencies through their decision-making, planning, implementing and evaluating processes for Community PROMISE. Community PROMISE TA providers can offer the following services:

- Assist with determining an agency's ability and readiness to attend the Course Two and Three in preparation for implementing Community PROMISE.
- Ensure attendance by the TA provider and CBO at Course Two and Three trainings.
- Assist in conducting the community identification process.
- Assist with designing and conducting interviews for role model stories.
- Build agency capacity to write role model stories.
- Strategize the recruitment and maintenance of the peer advocate network.
- Assist with conducting and using evaluation to improve the program.

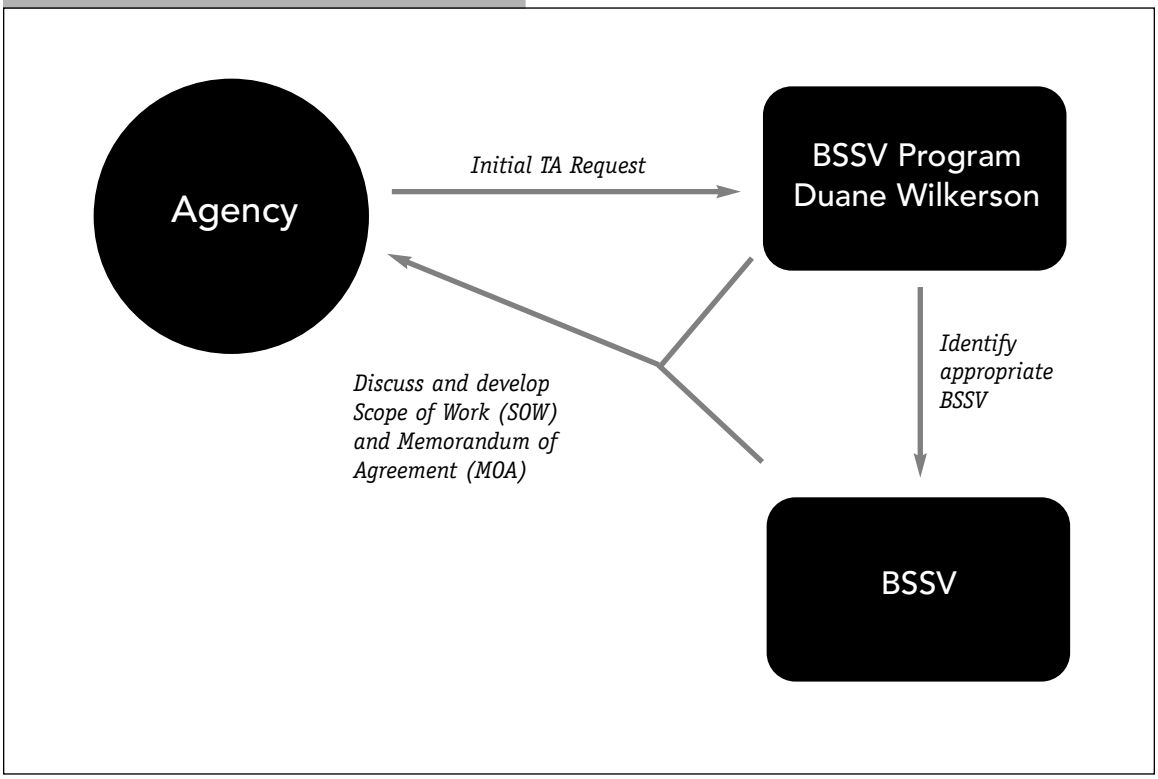
The primary TA providers for the Community PROMISE training program are the APA's BSSVs. This national network of psychologists, sociologists, anthropologists, and public health experts offer free and ongoing TA to CBOs, health departments, and STD/HIV-prevention community planning groups (CPGs). The BSSVs who will serve as Community PROMISE TA providers have been trained on the intervention and are highly skilled in providing TA on STD/HIV prevention programs.

Agencies will learn about the process for requesting and arranging TA from the BSSVs at the Course One training. This process is as follows:

1) Implementing agencies should first contact Duane Wilkerson, Director of the BSSV Program, at (877) 754-1404.
2) Mr. Wilkerson will conduct a needs assessment with the agency to determine the topics and areas in which assistance is needed.
3) Mr. Wilkerson will contact an appropriate BSSV to describe the request and secure an agreement for the BSSV's services.
4) A scope of work (SOW) among the BSSV Program, the BSSV and the agency will then be developed and agreed upon during a conference call. A memorandum of agreement (MOA) will be included in the SOW and will identify specific TA tasks.

The BSSV Program and implementing agency are responsible for including in this MOA a specific TA plan that meets the agency's needs. If an agency requires TA that is not specified in the original MOA, a new agreement must be established with the BSSV Program through Mr. Wilkerson. This TA request process can take place at any point along the agency's participation in the training, ranging from the Course One through the actual implementation of the intervention after all training is completed. Figure 3 illustrates the first phase of the TA request process.

Figure 3: TA Request Process, Phase I

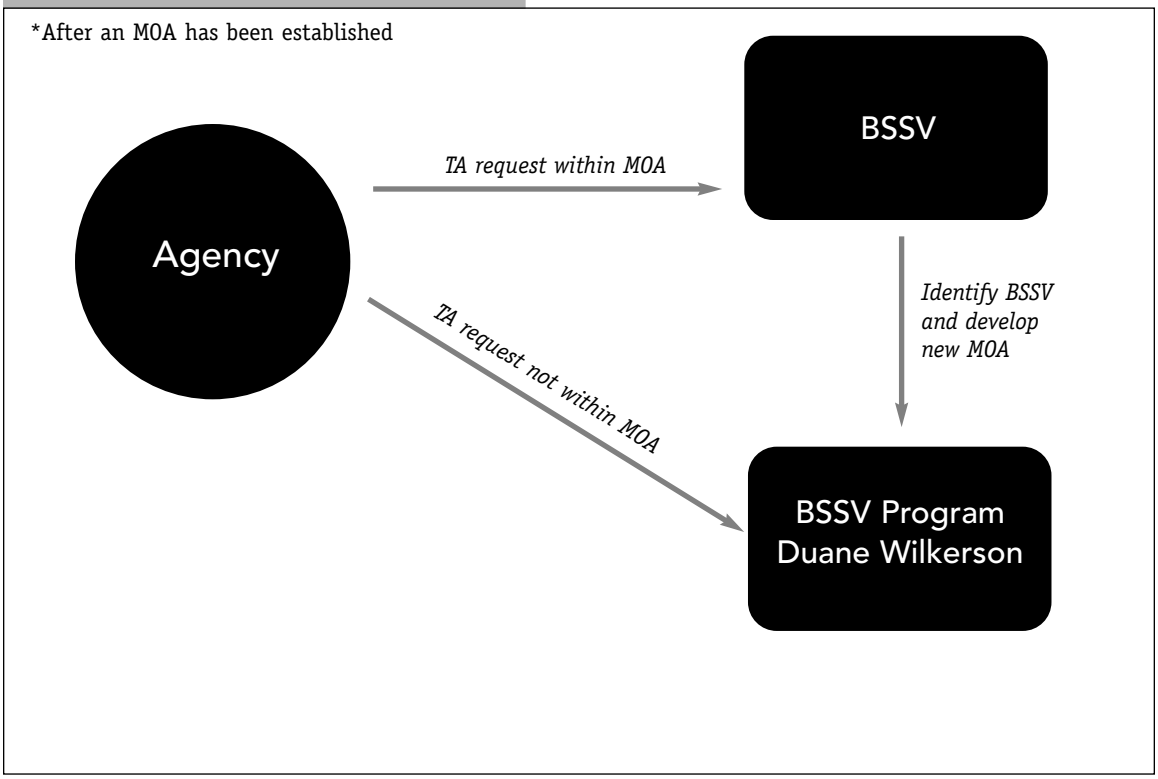


If and when the agency prepares to attend Courses Two and Three, they will have two options:

1) If they already have a MOA with a BSSV and TA for Course Two and Three is part of that MOA, the agency can contact the BSSV directly.
2) If the agency does not have an MOA with a BSSV, the agency must contact Mr. Wilkerson of the BSSV Program to request that a BSSV accompany them to the training.

Figure 4 provides an illustration of the second phase of TA.

Figure 4: TA Request Process, Phase II*



Section Three:
Review of Community PROMISE

Community PROMISE was developed in response to an urgent need for effective community-level interventions that could be reasonably carried out by local health departments and service organizations. Community PROMISE is based upon the experience of the AIDS Community Demonstration Project (ACDP). Funded by CDC, the ACDP found the intervention to be effective in five cities across the United States. For more information on the ACDP, you can refer to the Community PROMISE Implementation Manual appendices or visit the CDC website www.cdc.gov/hiv/projects/acdp/acdp.htm.

The "community" in Community PROMISE refers to two fundamental elements. The first is members of an at-risk community who generate the specific intervention content from their own experience. This content includes true risk-reduction stories shared by the intervention community itself—stories that model risk-reduction strategies for friends and members of the same target population within that community. The second community element refers to the broad risk community that is affected by the intervention, because not only do the active intervention participants change their behaviors but so do members of the broader risk community as a result of peer influence.

Community PROMISE is composed of four core elements, which are reviewed and illustrated in Figure 5:

- **Community identification process**

The community identification process provides implementing agencies with critical information about the community in which Community PROMISE will be conducted. This information includes risk-taking as well as risk-reducing behaviors of community members, locations where risk behaviors take place, factors that influence risk-taking behavior as well as factors that assist in reducing risk and foster positive behavior change. CID processes can take various forms, including interviews, focus groups, and questionnaires.

- **Role model stories**

Role model stories are personal accounts of individuals in the target population who have already made some risk-reducing behavioral change, such as starting to carry a condom, talking to a partner about condom use, using

condoms consistently, avoiding sharing needles, and getting tested for HIV or other STDs. Role model stories are created from interviews with these individuals. In the stories, individuals explain how and why they took steps to practice STD/HIV risk-reduction behaviors, and the positive effect it has had on their lives.

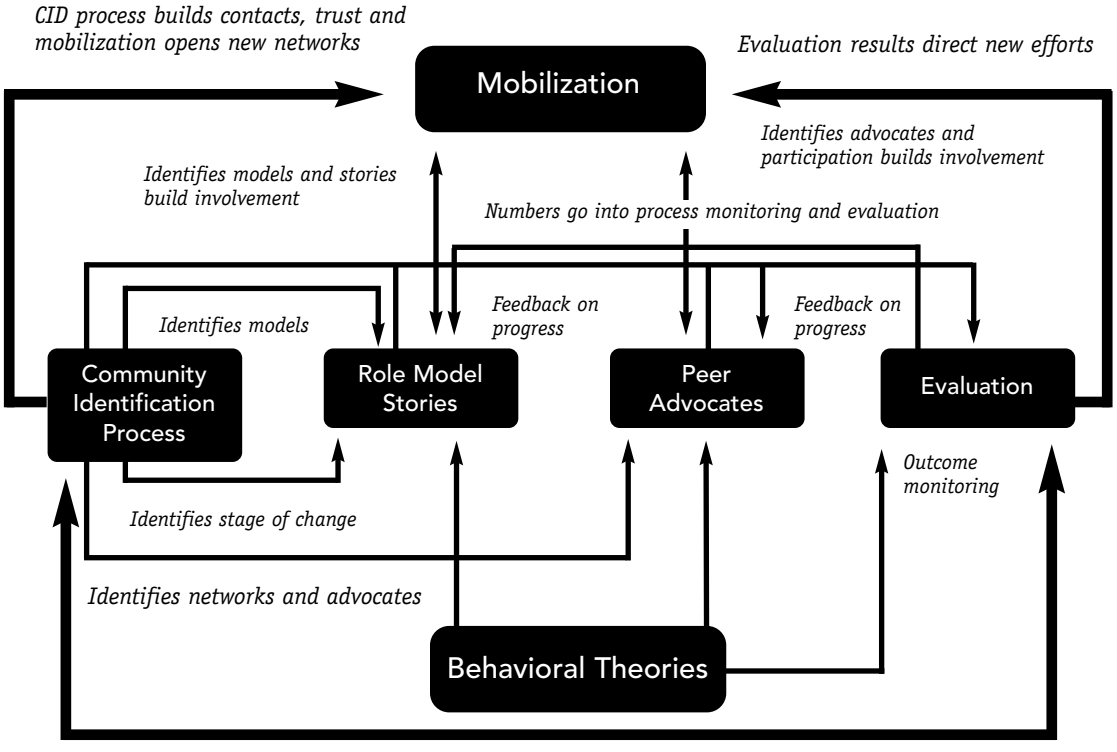
- **Peer advocates**

Individuals from the targeted at-risk communities are recruited and trained to become peer advocates and to deliver role model stories and other risk reduction materials to their peers in the community. As members of the social networks of the target population, the peer advocates are in a unique position to motivate and support positive behavioral change.

- **Evaluation**

Evaluation of Community PROMISE, or of any other behavioral intervention, is an important program management tool. Agencies need to evaluate whether the process of implementing the intervention is consistent with its design (process monitoring and evaluation) and if the intervention is meeting its objectives (outcome monitoring). In addition to helping agencies assess and improve their intervention activities, evaluation can provide important information to stakeholders such as funders, advisory boards, and the community.

Figure 5: Core Elements and Related Activities of Community PROMISE



CID process ongoing and monitors stage and diffusion for evaluation. Evaluation results are fed back into ongoing CID

Implementation Steps

The Community PROMISE training program introduces the steps and activities for conducting the intervention, and develops participants' capacity to carry them out. A summary chart of these steps is included in Appendix B of this manual and the comprehensive list is provided in the Implementation Manual, Module 6: Management. In addition to including all the planning and implementation tasks, the table in the Implementation Manual provides information on the corresponding capacity and knowledge necessary to carry out each task. Agencies will either already possess the qualities listed or develop them through the Course Two and Three skills based trainings and as they move through implementation. TA providers can use this summary chart to assess whether the implementing agency has carried out the necessary tasks and to respond to any problems or questions that have arisen in the process. A column has been added so that TA providers or implementing agencies can list comments of questions regarding each task.

Section Four: Implementing Community PROMISE

A: Decision Making and Getting Started

Community PROMISE is an effective, community-level STD/HIV prevention intervention that relies on role model stories and peers from the target community. The intervention is based on the Stages of Change theory and other behavioral theories. Community PROMISE begins with a community assessment to identify what STD/HIV risk behaviors and influencing factors are taking place within the community. Individuals from the targeted at-risk communities are then recruited and trained to be peer advocates. Peer advocates interview members of the community about their behavior and role model stories are written based upon the interviews. These stories provide personal accounts from individuals in the target population about how and why they took steps to practice STD/HIV risk-reduction behaviors. The stories also emphasize the positive effects the risk reduction choices had on their lives. Peer advocates distribute the role model stories and risk reduction supplies within their social networks.

The following are some questions that agencies may have while considering whether to adopt Community PROMISE or while preparing to conduct the intervention:

Q. *What are the main issues we need to consider when deciding whether or not to use Community PROMISE in our community?*

A. You and your agency may want to seriously consider adopting and using the Community PROMISE intervention if you feel that your community could benefit from augmenting your existing individual (one-on-one) and group-level STD/HIV prevention efforts with a program that can reach much larger numbers of individuals in your community. Community PROMISE, like other community-level interventions, may be particularly useful for reaching "hard to reach" individuals in your community. However, you must already have access to the community you are trying to reach, or be able to recruit and train individuals who do have access to the community. You may believe that your current efforts are not making as much of a difference in preventing STD/HIV as you would like, especially if your program is reaching a limited number of your target population at risk for STD/HIV.

You should also consider that Community PROMISE was found to be effective in reducing STD/HIV risk behaviors among several populations, including injection drug users (IDUs) and their sex partners, non-gay identified (NGI) men who have sex with men (MSM), youth at high risk, female commercial sex workers, and high-risk heterosexuals within Caucasian, African American, and Latino communities. If you are concerned about risk behaviors among any of these populations in your community, Community PROMISE may be a good fit to address your community's STD/HIV prevention needs. It should be noted that Community PROMISE also can be adapted to other settings and populations at risk for STD/HIV. If your community includes other populations at risk, you should consider whether Community PROMISE could be adapted to such populations.

Another factor to consider is that the Community PROMISE intervention is one of the more complex evidence-based interventions currently available. The intervention does require a commitment on the part of you and your agency, in that your agency will need to acquire comprehensive training in how to use the intervention. Community PROMISE will obligate personnel and other resources (see Question 2 below) to plan and implement the intervention in your community. Additionally, your agency should commit to using the intervention for at least 1 year, preferably much longer. The training is a necessary requirement for implementing the intervention, but it is also the reason why it can be easily adapted to fit your specific population's needs, while remaining true to the program's design and theoretical underpinnings.

***Q**. What are the bottom-line resources we need to effectively use the Community PROMISE intervention?*

***A*. Established Program:** First, your organization should already have an established STD/HIV prevention program and should have experience planning and conducting individual-level (one-on-one) and group-level (i.e., small group sessions that address STD/HIV knowledge, risk appraisals, and discussions and skill-building activities to reduce risk) program components. Experience with planning and conducting outreach, using small media (e.g., flyers, brochures), working with other agencies and local businesses also would be desirable.

Access to Target Population: Given that Community PROMISE is intended to effect change at the community level, you will need to have access to the target population(s). Therefore, if you want to intervene with a specific community of MSM or IDUs for example, you need to either already have access to this community or be able to develop and implement plans that will enable such access.

Staffing: The minimum requirement is one to two full-time outreach workers with a program manager who can devote at least part of his or her time to managing program implementation and supervising the work of the outreach workers. Implementing Community PROMISE

takes dedicated full-time staff. It will be difficult for an implementing agency to have staff work part-time on Community PROMISE and part-time on another intervention. A larger staff, especially more outreach workers, would be ideal, especially if the size of your target population is large and/or proves difficult to access.

Other Resources Needed: Your agency will need to have the resources to conduct a preliminary CID process that helps you learn more about your target population and its subgroups, clearly identify risk behaviors and barriers to behavior change among the population, identify and develop appropriate prevention materials and messages, and identify and develop necessary collaborations within your community (e.g., with other agencies and gatekeepers). Thus, you will need to have personnel (either internal staff or a consultant) who are skilled and experienced in conducting a CID process. These skills include developing and using data collection methods, such as interviews of key informants, focus groups with the target population, and observational methods; analyzing the data collected from these methods; and assisting you to effectively use results from the process. The Community PROMISE Implementation Manual, Module 2: Community Identification Process, provides detail on the CID process and provides sample data collection tools.

You will also need staff who are already skilled, or can acquire training, in interviewing members of the target population about their efforts to reduce risk behaviors, and also skilled in using information from these interviews to develop role model stories for distribution within your community. The Community PROMISE Implementation Manual provides much more detail on the process and resources needed for developing and using role model stories.

Resources also will be needed to publish the role model stories. If resources allow, the role model stories can be enhanced by using art, graphics, photos, colors, and high-quality printing. At a minimum, you will need sufficient resources to develop and produce black-and-white copies of the role model stories.

Some type of incentive (e.g., cash, food coupons) may be needed for peer advocates to distribute the role model stories within the target population.

***Q**. How much will this intervention cost?*

A. The chart below lists the key personnel necessary to implement Community PROMISE, including the number and percentage of time for each position. In addition, the position responsibilities and required skills and knowledge are listed. This will assist you in estimating personnel needs and costs.

Personnel: *(Pay rates vary by Community, so have been omitted.)*

POSITION	# @ x %	RESPONSIBILITIES	SKILLS & KNOWLEDGE
Program Manager	1 @ 25–100% *(depending on size of pgm.)*	Seeing that pgm. integrity is maintained; supervise staff & debrief them daily; assure that supplies & publications are on hand when needed, that peers are trained and encouraged; monitor data collection; request T.A.; explain pgm. to stakeholders.	Supervisory skills; excellent knowledge of program elements such that can train & supervise staff, explain to stakeholders; knowledge of outreach and local Community ; competent in all skills needed (CID, role-model stories, peers, basic evaluation).
Outreach Workers	1–4 @ 100%	Make contacts in Community ; collect preliminary CID data; recruit & manage peer advocates; recruit and maybe interview role models. Each to supervise 10-25 peers.	Knowledge of community ; comfort with target population; verbal communication skills; understanding of and commitment to project & its goals; taken CID & peer courses.
Role-Model Story person *(may be part of another staff member's job, if qualified)*	1 @ 40–50%	In collab. with mgr., identify and inform outreach workers about type of role-models needed; interview role-models; write role-model stories; prepare them for publication (layout, paste-up).	Interviewing skills; story-writing skills consistent with theory; desk-top publishing; has completed role-model story course, at minimum–preferably all courses.
Support Staff	1 @ 50%	Maintain program records, including data records (CID, process and outcome); order and follow-up on materials and publications; keep notes of debrief meetings & peer and staff trainings; duplicating.	Detail-oriented; good at record keeping & retrieval; can use data-base program of agency; understands concepts related to project; has completed overview course at minimum.

Other costs, beyond personnel, are listed below:

Basic Assumptions: One full-time outreach worker can effectively supervise from 10 to 25 peer advocates, depending on the distances from each other and from the office. Each peer advocate should be given from 10 to 20 packets of material each week or two to distribute to other members of the target population. Frequent (weekly) contact with peers keeps them working and provides management and training opportunities. At a minimum, one outreach worker X 10 peer advocates X 10 packets each to distribute X four weeks per month = 400 packets to deliver each month. Four outreach workers working 25 peers each at the same 10 packets a week X 4 weeks per month = 4,000 packets per month. These figures are based on a fully developed program. If you are just starting, halve the smaller figure, and build up from there. You should expect it will take a year before you will be operating a fully developed program.

Role-model story preparation for publication. If these are prepared in-house, using your own desktop publishing capabilities, the role-model story can be produced by your publication person, the time and costs of which are included above (for the role-model publications). If you must purchase outside services, the cost will increase. Even donated time may cost something in your time and materials.

Printing. Four-color printing may not be necessary. Your advisory board and focus groups held specifically to examine materials will guide your choice as to design, photographs or drawings, etc. Printing from your color or black-and-white printer may be sufficient. Assuming you use a small, local duplicating service at 10¢ per page side, for 20¢ each, you could print a four-page folded newsletter containing two role-model stories and other referral information for your population. Presuming you distribute 400 per month, your printing cost would be $80 per month or $960 for the first year.

Accompanying materials. Condoms may be purchased in bulk for less than 10¢ each. Your advisory board and focus groups held specifically to examine materials will provide you with information on how many to package with each publication (1–3, probably). Bleach kits, if you distribute them, can be purchased or you can assemble them yourself. Doing it yourself will only cost less than 50¢ each, and once you get going, you can get volunteers to assemble them once a month under staff supervision. Zipper-top bags for packaging all these cost a couple of cents each. Small one-time packages of lubricants are slightly more expensive than condoms, but should be distributed if your target population has told you that it is important. If you distribute 400 packages a month, your costs may be about $200 per month ($2,400 per year); multiply for additional quantities. Appendix S provides vendors of prevention materials.

Mileage. If you pay mileage to your outreach or other staff, calculate the costs of daily trips to the sites where peers and target population members will be found, since your outreach staff will be out in the field more than in the office.

Role-Model Incentives. Role-models can be paid for their time to be interviewed. This may cost as little as $5 for an interview or as much as $25, depending on the population and your region. Your advisory board can help with this decision. An extensive interview will provide data for up to three or four role-model stories, and less detailed interview may provide information for only one story. If you publish one or two stories a month, this is still only $25 per month ($300 per year). You can also provide non-monetary incentives, discussed below.

Peer-Advocate Incentives. You may find it useful to provide incentives for your peer advocates. Small gifts (ranging from candy to fast-food coupons to t-shirts) will cost from $2 to $10 each. Do not give a gift more often than once a month. Less often may be workable, depending on what is indicated by your advisory board and your experience with peer advocates. Monthly gifts averaging $3.50 per month for a dozen peers will cost $42 per month ($500 per year).

Peer-Advocate Parties/Events. Social events for peer advocates can take place once or twice a year, depending on your area. These may be barbecues in a park, indoor picnics in a local recreation center, or something similar, at which the peers may provide music, the staff may provide skits, and the program provides food, certificates, and small gifts of appreciation (which may be donated by local

merchants). Peer advocates may invite their immediate families. The event could cost $500 (perhaps less if community businesses contribute). Other ideas include bake sales or garage sales where items are donated and then sold by peer advocates. Those advocates who participate can then split the proceeds from the event as an incentive. This type of event teaches the advocates organizational skills and is very satisfying since the results are so tangible.

Community Storefront. You may choose to locate and rent a storefront, small apartment, or other facility in the target community which can serve as the base of operation for the outreach workers and peer advocates. This gives you a place to keep program materials, interview role models, and hold advisory board meetings as well as peer advocate trainings. Strongly consider this if your existing office is not in or near the target community . Costs may include rent, utilities, renovations, insurance, security systems, etc. You might find an existing organization that has space that is available during the times you need it.

Key Participant Survey Incentives and Key Observor Incentives. As part of the initial and ongoing CID process you will be interviewing members of the target population. Since these surveys (especially the key participant) are lengthy you may decide to offer them an incentive for their time. This could be a store gift certificate or fast food certificate. Again, your advisory board can assist in identifying appropriate incentives. The ongoing CID may also include some brief interviews with key observers. These interviews, while short, may be repeated over time with the same people so it may be advisable to provide them with periodic incentives.

General costs. As with any intervention you will have costs for overhead items: space, utilities, insurance, furniture, telephones and phone service, at least one computer and, perhaps, Internet access.

Total costs of the non-personnel intervention specific expenditures mentioned here would be a minimum of $5,000 per year. This includes printing, accompanying materials to be packaged with the role-model story publications, and incentives and parties for the peer advocates. Almost half of these costs are for the accompanying prevention materials—condoms, bleach kits, etc.

Q. *What type of training in Community PROMISE should we get that would help us to effectively use the intervention? And how do we go about getting trained?*

A. Under the DEBI project, CBOs and other agencies with a need and capacity to implement Community PROMISE can receive training on the intervention. The Community PROMISE training program is composed of a series of three courses—one foundational and two skills-based. The first course provides a comprehensive overview of the core elements and the steps for conducting and managing the intervention. This course enables participants to assess whether or not the intervention is appropriate for their organization and community. If you decide

that Community PROMISE is a good fit, your organization can move on to the two skills-based courses that cover the details of the CID process, writing and distributing role model stories, and recruiting and training peer advocates. Each of these two courses helps participants develop the knowledge and skills necessary to carry out the core elements of Community PROMISE. Through interactive training activities and field-based work, participants are provided with the tools to make Community PROMISE happen in their community. Participants must attend all three courses to fully prepare for implementing Community PROMISE.

Q. *What materials should we review that would help us learn more about Community PROMISE?*

A. A number of print materials and websites are available to help you and your agency learn more about Community PROMISE. As previously mentioned, the Community PROMISE website (www.effectiveinterventions.org) provides a brief fact sheet that includes a program overview, description of core elements, description of appropriate target populations, list of program materials, and an agency readiness self-assessment instrument that is relevant to the Community PROMISE intervention.

The CDC web page on the AIDS Community Demonstration Project (www.cdc.gov/hiv/projects/acdp/acdp.htm) provides more information and resulting data from the five city study. For more comprehensive information, you can review the Community PROMISE Implementation Manual, which provides a description of the intervention and its core elements, a step-by-step description of all the Community PROMISE intervention components, a number of tools to assist in planning and implementing the intervention, and a list of resources. The Implementation Manual provided to individuals and agencies that attend the CDC-funded Community PROMISE trainings.

Q. *Who can we contact that might help us better understand Community PROMISE and help us to decide whether Community PROMISE is right for us?*

A. If you want more information about Community PROMISE you can contact the National Network of STD/HIV Prevention Training Centers or the Academy for Educational Development:

California STD/HIV Prevention Training Center
1947 Center Street, Suite 201
Berkeley, CA 94704
Phone: (510) 883-6600
Fax: (510) 849-5057
E-mail: CAPTC@DHS.CA.GOV
www.stdhivtraining.org

The Dallas STD/HIV Behavioral Intervention Training Center
University of Texas Southwestern Medical Center
400 South Zang, Suite 520
Dallas, TX 75214
Phone: (214) 944-1068
Fax: (214) 944-1061
http://www2.utsouthwestern.edu/cpiu/preventiontrainingcenter.htm

Denver STD/HIV Prevention Training Center
Colorado Department of Public Health and Environment
DCEED-STD-A3
4300 Cherry Creek Drive South
Denver, CO 80246
Phone: (303) 436-7267
Fax: (303) 782-0904
http://depts.washington.edu/nnptc/regional_centers/centers/denver.html

New York State STD/HIV Prevention Training Center
Center for Health and Behavioral Training
691 St. Paul Street, 4th Floor
Rochester, NY 14605-1799
Phone: (585) 530-4382
Fax: (585) 530-4378
http://depts.washington.edu/nnptc/regional_centers/nysptc/about/aboutbt.html

Academy for Educational Development
Center on AIDS and Community Health
DEBI Project
1825 Connecticut Avenue, NW
Suite 900
Washington, DC 20009
Phone: (800) 462-9521
Fax: (202) 884-8474
Email: interventions@aed.org
www.effectiveintervetions.org

Q. *How do we go about the process of deciding if Community PROMISE is right for us?*

A. In deciding whether Community PROMISE is right for your agency, you should involve key staff and stakeholders (e.g., executive director, program managers, field staff, members of the target population) in examining and reviewing the purpose, program components, program activities, and intended benefits of Community PROMISE. This review should involve a group process in which open and frank discussion is facilitated and consensus can be built.

The literature on adopting and implementing a new intervention provides some guidance that can help you decide whether or not to pursue Community PROMISE. First, your agency should decide to what extent Community PROMISE offers more advantages to the agency and community, compared to existing STD/HIV prevention programs. Advantages could be viewed in terms of cost, convenience, likely satisfaction among those who use and those who are the recipients of the intervention, and even prestige and status (to your funders and within your community).

Second, you should assess the extent to which Community PROMISE is compatible with the existing values, mission, past and current program experiences, and needs of your agency and community. For example, if your agency accepts the idea that a target population will reduce their risk behaviors through a staged process that takes time (i.e., the Stages of Change model that is the theoretical foundation of the Community PROMISE intervention), then Community PROMISE may be a good fit.

Third, you will need to seriously consider if your agency can effectively address the relative complexity of the Community PROMISE intervention. As mentioned before, Community

PROMISE is comprised of numerous program components that are comprehensive, and sometimes complex. Your agency will need to be assured that all personnel involved will be able to understand and implement the various intervention activities (e.g., interviewing for role model stories). Your agency may want to try out, on a limited basis, part or parts of the Community PROMISE intervention. Trying out a part of Community PROMISE may provide your agency with some very useful information or data about whether or not Community PROMISE will work for you.

Fourth, your agency staff may want to consider to what extent results from using Community PROMISE can documented and observed. Being able to identify and describe even short-term behavioral outcomes among the target population would be helpful in justifying ongoing use of Community PROMISE.

Q. *What kinds of qualifications do the various staff members on this program need?*

A. Appendix B: Implementation Steps, provides summary information on the specific capacity and knowledge needed for all Community PROMISE tasks.

B: Conducting the Community Identification (CID) Process

An essential element of carrying out Community PROMISE or any other STD/HIV prevention program, is to be highly knowledgeable about the target population. Expansive research in STD/HIV prevention has told us that an intervention cannot be effective unless it is tailored to a specific target population and the behaviors that put them at risk. Although Community PROMISE implementers may feel they are already familiar with the target population, they may not have all the knowledge needed to design an effective program. Any target group is made up of sub-groups of people who are both similar and different from each other in a number of ways. Understanding these similarities and differences, especially in regard to risk behaviors, personal meanings of these behaviors and the context in which risk takes place, can help "fine-tune" an intervention and make the difference in achieving outcomes and strategically using limited resources.

Community PROMISE implementers will have attended the formal training program and initially learned about the CID process. However, they often require additional assistance with deciding how to implement the program with fidelity. An important role of a TA provider, therefore, will be to both sell the need for the CID process and assist agency staff with research activities that they may not have done in the past.

The TA provider's primary responsibility is to help staff carry out the intervention's core elements with fidelity. This means helping them understand ways in which the intervention can—and cannot—be altered without sacrificing program effectiveness. Staff may develop a sound strategy for conducting the CID process, but they may confront unforeseen challenges. In some situations they may decide to make changes in the formative assessment process. In others, it may be up to the TA provider to troubleshoot problems and work with the agency to address barriers and get back on track.

This section contains information TA providers need to help agency staff plan and conduct a preliminary CID process and obtain critical information about the target population. It includes questions and answers related to four issues that were identified during field testing:

- Understanding the benefits of the CID process
- Building trust and recruiting participation of the community
- Summarizing and using gathered information from the CID process
- Special considerations

Understanding the Benefits of the CID Process

Sometimes you will find that an agency's staff members are not familiar with the CID process. Although attending the Community PROMISE training may have heightened agency staff's knowledge and enthusiasm for doing such an assessment, once back in the field they may be unable to devote the resources needed to conduct the CID process and carry out the many other responsibilities of their job. Other staff at the agency who did not attend the training may not be familiar with the CID process and may question its importance. This requires the TA provider to review the CID process, its objectives, and the importance of it as an essential first step in the intervention.

Here are some questions that Community PROMISE implementers may ask about the CID process:

Q. *We feel we already know the target population. Why do we need to conduct a CID process?*

A. You may feel you are already very familiar with the target population. However, you may be surprised to find out that there is much you do not know. Other agency staff who have engaged in the CID process have learned this lesson. They have found out that some of their knowledge consisted of stereotypes and misconceptions that they had about the community and the target population which, when re-examined, were changed. They found that they sometimes generalized about the target population, its risk behaviors, the context that the behaviors take place, and the barriers the population faced. Engaging in the discovery process of CID helped them understand that there were many differences and similarities across the target population that needed to be considered in designing an effective prevention message and program.

The CID process brings together the perspective of community outsiders as well as insiders to develop a comprehensive knowledge about the target population. Outsiders, also sometimes called "interactors," are those who work with the people at risk of STD/HIV in the community, people who may observe them everyday, or people who may serve them in other ways, but are not part of the target population. Shopkeepers, taxi drivers, beauticians, and others are examples of outsiders. Insiders, also sometimes called "gatekeepers," are individuals who are directly part of the intimate networks of those at risk, such as a drug dealer, pimp or other. Insiders also include the individuals themselves who are taking part in the risk behaviors, such as IDUs, sex workers, high-risk youth, and non-gay identified MSM. The perspective of any one of these sources may not provide an accurate snapshot. When they are put together, however, they can provide a true and comprehensive picture of the community and those at risk of STD/HIV.

If your agency has already collected data on the target population before implementing Community PROMISE, this can be helpful. However, it is important to recognize that some of the information may not be up-to-date and may misinform your program design. The circumstances under which networks of drug users meet to buy, sell, or use drugs, for example, may have changed due to several factors. Having some prior data on the target population, therefore, should not replace the larger CID process. These prior data can be reviewed in the agency's initial brainstorming about the target population and can be used to validate the information you collect during the CID process or demonstrate that certain changes may have taken place.

Another benefit of the CID process is that it allows you to collect other types of information required by Community PROMISE. For example, Community PROMISE requires that you identify the stage(s) of change of your target population. The CID process can help you acquire that new information.

Conducting the CID process can benefit you in other ways as well:

- The CID process helps mobilize the community. The process allows you to develop new linkages and relationships with community agencies and leaders that will assist you in learning more about the target population and will benefit the larger implementation of Community PROMISE as well as other interventions that your agency may conduct. Engaging people in interviews makes them feel valued. In particular, interviewing agencies with which you did not have prior contact can generate new collaborations, such as with criminal justice agencies or local merchants.

- The CID process helps build community trust. The process helps you develop increased trust with the members of the target population that will enhance the credibility of Community PROMISE and encourage their volunteer participation in the program. Interviewing them as part of the CID process elicits their views, gives

them a voice to tell their story, and validates their STD/HIV prevention needs. Generally, social services in this country have had a lengthy history of developing interventions that deal with how professionals see the problem and not how the community sees it. This approach has lead to failure and distrust by the community and it is not something that we should repeat.

- The CID process builds an informational base for continued planning. The process provides empirical, scientific data that can be used to help plan Community PROMISE and also to develop grant proposals and plan other STD/HIV prevention interventions. As the field of STD/HIV prevention evolves and resources become more limited, funders increasingly expect that applicants will present a strong, scientific rationale for needing their resources and proposing a specific approach.

Building Trust and Recruiting the Participation of the Community

The CID process requires that implementing agencies get an accurate snapshot of the community, which cannot be complete without an insiders' perspective of the target population. To obtain this perspective, implementers need to acknowledge the underlying distrust within the target population and identify how to build trust to both facilitate the CID process as well as the overall intervention. Part of the role of the TA provider will be to assist Community PROMISE implementers in doing this.

Individuals from vulnerable communities have many reasons for not trusting others and not being open with them. The mere act of survival often has exposed them to dishonesty, theft, and violence from others in their immediate environment. The realities of survival and addiction mean that individuals often are engaged in illicit behaviors that they have to hide from "outsiders," including the authorities and others they suspect could cause them harm. Sometimes, they do not trust those in the system who are there to offer help. Unfortunately, many individuals in vulnerable communities consider authorities and other representatives of "the system" to be quick to judge and inconsistent with the help that is offered. Thus, those who live on and/or work the streets are highly sensitive to whom they let in to their world and who may be suspect.

Here are some questions that Community PROMISE implementers may ask about building trust in the community so as to facilitate the assessment process:

Q. *How do you build trust in a community?*

A. Before you can conduct the CID process with insiders, you must first develop a rapport with the community. Developing a rapport requires that you give consistent support and are regularly visible in the community. Building trust with the community does not come overnight. It comes from building relationships with target population members one at a time. In this way, the community can observe over time that the organization you

represent and the behavior of the staff is caring and helpful to the defined needs of the community.

Building trust in a community requires that your agency is consistent—if staff members say that certain services or benefits will be delivered, they must be delivered. It requires that outreach workers and other staff be respectful of the people they are serving and that they can explain their actions and the reasons behind them in a way that the target population understands. As a trainer of Community PROMISE has articulated, the target population needs "to feel you" in order to sense that what you say will have relevance for their lives.

Although many organizations have found that trust-building is facilitated by matching their staff with the target population on such characteristics as race/ethnicity or risk factor, field experience from Community PROMISE has found that this is not always the case. What was identified to be more important was the personality of the individual staff person and their ability to relate to the target population and verbalize what it is they are trying to accomplish. Staff must understand their own personal limitations and be open to receiving feedback from more experienced staff on how to relate to and serve the target population. In addition, any individual who is going out into the field must be comfortable with the risk environment, whether it be a crack house, a public sex venue, or other location that the target population frequents.

Q. *We're a health department using Community PROMISE. We know that building trust in the community can be hard. What do you suggest?*

A. Members of the target population generally distrust government agencies for several reasons. Health departments often lack a familiarity and connectivity with the target population, which can make it difficult to successfully complete the CID process. To overcome this barrier, health departments and other large organizations that lack a community connection may want to collaborate with community-based organizations that have better access to and rapport with the target population.

A benefit of Community PROMISE is that is relies on the participation of peers from the target population, who are already part of and have unique access to intimate social networks that may be in accessible to outsiders such as health department staff.

Q. *We are having trouble recruiting members of the target population for the key participant interviews. What do you suggest?*

A. One of the most effective methods of gaining trusted access to the target population is through gatekeepers. Within a given target population, gatekeepers are important because they can allow or prevent an outsider's entrance into a community. They are often informal leaders who are respected or admired. Being endorsed by a gatekeeper often allows a person who is not part of the community to be accepted by the target population. Additionally, some of the ACDP

sites offered key informants a $5 incentive or coupon to encourage participation.

How do you identify gatekeepers in the community? Some gatekeepers could be identified at the beginning of the CID process during surveys with internal staff. Outreach workers, for example, who regularly observe and service the community, are often best informed of whom the gatekeepers are. Gatekeepers can also be identified by surveying external sources of information, such as service providers (e.g., in CBOs, judicial system, healthcare, drug treatment) or interactors (e.g., hairdressers, shopkeepers, bartenders). It is important to recognize that gatekeepers often can be members of the target population--for example, a drug dealer who may occasionally use drugs.

Gaining access to the target population through gatekeepers is not just a matter of asking questions about the target group members. As discussed previously, a level of trust must be established between the agency and the gatekeepers. Those who interact with the gatekeepers and conduct interviews with them must learn their language and learn an appropriate posture before gaining access to the target population. Agency staff must be fully prepared to familiarize gatekeepers with the project, in terms that they understand. In addition, the interview should stress how important a gatekeeper is to the CID process and to the project. Finally, if the gatekeeper offers information about members of the target group and where to find them, agency staff should be prepared to follow-up on every lead that is given.

Summarizing and Using Gathered Information from the CID Process

Conducting the CID process using the Good, Better, or Best options described in the Community PROMISE Implementation Manual, Module 2: Community Identification Process, can generate a lot of paper (e.g., completed surveys, focus group transcripts) and information. Agencies can feel overwhelmed with what to do with the information and how to use it. Without assistance in these situations, agency staff can become frustrated, critical of the time they put into the CID process, and less invested in implementing Community PROMISE. It is the role of the TA provider to assist that agency in these situations and/or to identify other technical consultants so that the information can be systematically analyzed, summarized, and used for program planning purposes.

Here are some of the questions that Community PROMISE implementers may ask about summarizing and using gathered information from the CID process:

Q. *We have mounds of completed surveys and focus group interview data. How do we analyze and summarize all of this?*

A. A TA provider can initially assist agency staff with systematically reviewing the information they have collected in the CID process so they can begin to appreciate the data collection tasks they have performed. Before trying to analyze the data, it is helpful to review the original objectives of the CID process and the questions that the agency was

trying to address through data collection. Every agency may have somewhat different objectives or questions, but some of the major ones include:

- What is the composition of the target population and the subgroups within it?
- What are the best places and ways to access the target population? Who are some of the identified gatekeepers?
- What are the risk behaviors of the target population/subgroups, the context in which they occur, and the population's current stage of change?
- What barriers exist that inhibit behavior change by the target population and how can these barriers be overcome?
- What does the target population believe to be the appropriate and relevant risk-reduction messages, methods, and materials?
- What other agencies or organizations serve the target population and what services do they provide?
- What agencies and community members have been reached and to how are they willing to support Community PROMISE?

If the agency has initially reviewed the data before formally analyzing them, it can be helpful to guide a discussion regarding what the staff have initially learned from the information to help answer some of the CID process questions and objectives. To more thoroughly understand the collected data, the TA provider can help the agency develop a plan for data analysis. If the agency has gathered both quantitative and qualitative data, they will need to understand the difference between these kinds of data and the methods/techniques that can be used to analyze them. This may entail explaining database development (i.e., Excel, SPSS), data entry and analysis for quantitative data. For qualitative data, the TA provider can do an exercise with staff in which they listen to 5-10 minutes of a taped focus group interview and identify themes across what is being said by the interview participants. If the agency does not have staff to assist them with the overall analysis of data, the TA provider can help the agency identify other sources of assistance, such as interns from local colleges or universities, CDC's Capacity Building Assistance network or, if resources allow, professional research consultants.

The agency also can analyze the data through a data reduction and summarization process that is done by hand or through a simple computer program like Excel. To conduct the process by hand, the agency should write each question on one piece of paper and tally the answers. All the results for each question will be on one piece of paper and can easily be summarized.

As the data are analyzed, it is important that the agency staff review the results together to identify discrepancies, challenge their reliability and validity and see what information is still needed in order to comfortably make conclusions and decisions. This is also a time when staff can identify any false assumptions about the target populations that may have been made from field observations. If members of the staff are members of the target population, their

participation during the debriefing session can add some depth to the CID findings that are being generated.

Q. *How can the information we have gathered inform us of how to define "community" in order to conduct Community PROMISE?*

A. Some agencies that are implementing Community PROMISE may be confined to defining community based on constraints of funders. For example, an agency may receive funds from a health department that has identified priority populations through HIV Prevention Community Planning. Ultimately, both prevention planning and the CID process are conducted to identify those populations most in need of STD/HIV prevention programming.

The CID process also should be designed to generate data that identify target "communities" based on other practical factors. As a community-level intervention, Community PROMISE works best when it is trying to reach social networks of high-risk populations. It also can be conducted more efficiently if these social networks congregate in locations that are relatively accessible for outreach. For example, NGI MSM may not constitute a "community" in a formalized sense, but the CID process for one agency may conclude that this can be their defined "community" based on the following factors: 1) a significant number of these men engaging in high-risk behaviors are part of social networks; 2) these social networks of NGI males congregate in certain locations that are accessible to Community PROMISE staff and volunteers; 3) agency staff already have expertise with working with this population; and 4) the agency have collaborative relationships with other organizations that are able to sensitively address other needs of the target population in addition to STD/HIV prevention.

Similarly, results of the CID process may also identify subpopulations of a high-risk population that may not be practical to reach with the intervention. Community PROMISE implementers in Long Beach, for example, found from their CID process that several subpopulations of high-risk sex workers existed, including those who worked on the street and those who worked for escort agencies. They opted to not conduct Community PROMISE with women who work for escort agencies because they found they were less inclined to be in social networks, less accessible through outreach, and because their staff did not have prior expertise in working with these women.

Q. *The information from our CID process has told us that our agency cannot address several needs of the target population. What should we do?*

A. Vulnerable, high-risk populations such as IDUs, sex workers, the homeless, and others, are composed of people who have multiple needs that have not been adequately addressed. TA providers should encourage Community PROMISE implementers to work collaboratively with organizations that can respond to other needs of prioritized populations. These collaborations may have been built with outside organizations as a

result of prior partnering arrangements or they can be built during the CID process. It is strongly recommended that implementing agencies develop a referral list with agencies that provide the needed services. The referral list should have clearly identified and verified contact information. Another suggestion is to hold a "resource fair" in the neighborhood and ask other agencies to attend.

A major objective of the CID process is to promote positive responses to Community PROMISE by conducting community mobilization through a process that systematically involves all possible interpersonal connections with the target population. This requires that agencies establish a network of relevant individuals, organizations, agencies, and businesses that can assist with the distribution of role model stories and prevention materials as well as function as referral sources when the needs of the target population can not be met by the implementing agency.

Special Considerations

Conducting the CID process has similarities to conducting "human subjects research." Methods that agencies may use to better understand the community, such as individual surveys or interviews with target group members, can generate highly confidential information related to STD/HIV status and risk behaviors. Agency staff will need to be aware of ethical considerations for conducting this type of activity and the treatment of the individuals who take part in it. TA providers should be prepared to answer questions related to these topics such as those listed below.

Q. *How should we protect individuals who provide us with information during the CID process? Will we need to obtain consent from people we interview?*

A. Agencies should be guided by their own internal policy on such matters as well as by funders' requirements. Any time personal information is gathered during a survey or interview, the interviewer or survey administrator should provide the participants with a consent form that should outline the benefits and risks in the person's voluntary participation in the survey/interview activity (see the Community PROMISE Implementation Manual, Appendix L: Consent to be Interviewed Form). The interviewer or survey administrator can read the form aloud and should answer any questions that the participants may have before they are signed. The role model should sign the form before the interview and be given a copy to keep.

Another important practice in protecting the CID process participants and the information they provide is to use anonymous data collection protocols. Signed consent forms may be used before information is elicited, but all surveys and collected data should be anonymous. This means that the information is not linked with any personal identifiers that could be traced back to a particular person who has given consent. In addition, anyone involved with implementing the CID process should be trained in protocols of confidentiality. This means that any information that they may collect should remain confidential and that individuals violating the confidentiality of particular data

and their sources will be disciplined by program management.

Q. *When developing role model stories, how can we ensure that the people interviewed are properly informed about how we will be using their role model story?*

A. Agencies should use the same consent process when interviewing individuals for role model stories as they use during the CID process. If a signed consent form is not currently a requirement of your agency, it is a good idea to develop one. Review the consent form verbally with the potential role model before you begin the actual interview. Have the role model sign the form before the interview and give them a copy to keep Another very important thing to remember is that you must record the role model's name and any nicknames he or she may have when you conduct the interview. By also recording the nicknames, you avoid accidentally using any of these names in any of the stories that comes from the interview, assuming the person does not want you to use their real name or nickname.

The role model should also be shown a copy of the publication in which the story will appear. This ensures full understanding of how the information will be used; it also prevents misunderstandings after the story is published. This also allows the role model to feel comfortable and know that nothing in the story will reveal his or her true identity unless he or she has given permission.

C: Recruiting and Training Peer Advocates

In order for Community PROMISE to be successful, focused distribution of specific types of STD/HIV prevention materials to members of the target population must occur frequently. During Community PROMISE training, participants learned about the important advantages of using volunteer peer advocates to distribute these materials and reinforce prevention messages and the behavioral change. Peer advocates are members of the target population and have immediate credibility with them–credibility that it may take agency staff a long time to develop. They also have access. Advocates can distribute and communicate with the target population at times, in places, and with people that agency staff may never see in their regular outreach work. Additionally, using volunteer peer advocates has economic advantages for agencies that have limited prevention dollars to conduct Community PROMISE.

In order to effectively use peer advocates in Community PROMISE, agency staff need to know how to recruit appropriate individuals and provide them with adequate training. Not all members of the target population are suited for this type of prevention work and when inappropriate individuals are recruited or recruits are not properly trained, agency staff can become distracted with problematic management issues and experience a lack of success with the intervention. TA providers can be helpful to the agency in this regard. They can advise agency staff on how to effectively recruit peer advocates and can help

staff solve problems when recruitment becomes difficult. TA providers can also assist agency staff with planning an effective training of peer advocates and identify ways of customizing training for peers who are not able to participate in formalized training.

This section contains information TA providers need to help agency staff in the peer advocate aspects of Community PROMISE. It includes questions and answers related to these two issues that were identified during field-testing:

- Effectively recruiting peer advocates
- Effectively training peer advocates

Effectively Recruiting Peer Advocates

As stated above, not all members of the target population will make good peer advocates for implementing Community PROMISE. Although agency outreach staff may have contact with a wide variety of individuals in the field, staff need to develop criteria to ensure that they appropriately approach and recruit individuals to be effective peer advocates for Community PROMISE. For those agency staff who did not attend the Community PROMISE training, the tendency may be to try to recruit any target group member who they may regularly see in the field without considering certain factors that are important in the recruitment process. In addition, agencies that do not have ongoing and regular contact with the target group in the field may be inexperienced with how to approach and identify appropriate peer advocates. Recruiting peer advocates takes time and networking and Community PROMISE implementers should set reasonable expectations for themselves. TA providers assisting in this area should initially assess the agency's experience and expertise with interacting with target group members and its access to them, including its extended network to reaching them. They should also review staff assumptions and plans about recruiting effective peer advocates.

Here are some questions that Community PROMISE implementers may ask about recruiting peer advocates:

Q. *How can you tell whether someone will be an effective peer advocate?*

A. Not every member of the target population is appropriate as an advocate. Agency staff should develop criteria before starting the recruitment process. Here are some the characteristics of effective peer advocates that have been identified in the past implementation of Community PROMISE:

- *Non-judgmental*. Advocates should not be judgmental toward other members of the target group and their behaviors. For example, target group members who have entered into substance abuse recovery can often be highly judgmental of individuals who are still active users. This attitude is not appropriate for being an effective advocate.

- *Won't try to reform target population members or impose a hidden agenda*. Advocates should not try to impose their own agenda on the individuals they

encounter. For example, individuals who want to reform target population members by recruiting them into their own program or religious group should not be invited to become advocates.

- *Lives or spends time in target area and plans on staying in the area.* Advocates should have spent time or lived in the local community for more than 6 months with plans to remain in the area for the next year. Ensuring that advocates have good connections with target population members will minimize turnover.

- *Can be reliably contacted.* Potential advocates must have a reliable way to be contacted. This can be a permanent living situation (whether in an apartment or a regular place they stay on the streets), a regular hangout, a pager, a person to leave messages with, or a connection with other advocates who may be able to locate them.

- *Is active in a social network of peers and considered a credible source of information.* Advocates need to be individuals who are well connected within social networks of peers, are respected by them, and considered a credible source of information. Target population members who are isolated and do not regularly interact with peers, or are active but not respected by peers, are not likely be effective in furthering the Community PROMISE community intervention. To assess these traits, outreach workers should observe a potential peer advocate and his/her interactions and level of contact with peers.

- *Is willing to distribute prevention materials.* Advocates should communicate a willingness and commitment to wanting to distribute the prevention materials to their peers.

It is important for agency staff to recognize that effective advocates do not all need to be members of the target population. Some can be business advocates, also known as interactors. Good business advocates should be individuals, such as a beautician at a salon, a merchant of a store, or a motel clerk, who are geographically located near the places target population members congregate and who regularly interact with them.

In recruiting effective advocates, agency staff should be conscious of the geographical areas and social networks of potential recruits. If most of the advocates are from one geographical area, it is likely that they will saturate that area quickly and miss the opportunity to distribute stories to a diversity of areas. Likewise, if many of the advocates are friends or interact in the same social circles, the level of distribution to differing social networks will be limited. In summary, an "effective" advocate will be an individual who, when combined with other recruits, will be able to reach a wide segment of the target population and promote the impact of Community PROMISE.

Q. How should we recruit peer advocates?

A. If you are a TA provider who is working with an agency from the beginning of their implementation of Community PROMISE, you should encourage the agency to recruit peer advocates during the CID process. Identifying potential peer advocates can take place as a result of interviews with interactors (i.e., business people in the community such as taxi drivers, shop employees, motel clerks) or external service providers (e.g., of other AIDS-service organizations, teachers, law enforcement, drug treatment) who regularly interact with and/or observe the target population. In the course of interviewing these contacts about their knowledge of the target population and their risk behaviors, they can be directly asked about the names of members of the target population who take part in the risk behaviors.

Gatekeepers, another category of individuals who are part of the CID process, are also an important source of information about potential peer advocates. Further, in conducting community mobilization to market Community PROMISE, several individuals who are highly knowledgeable of the target population, like those on the project's Advisory Board, can make suggestions of who might make effective advocates.

Whether potential advocates are identified and recruited as a formal part of the CID process or not, implementing agencies should follow several important steps for recruiting peer advocates:

- *Establish a community presence.* Depending on how familiar target population members are with your planned Community PROMISE intervention, it may be necessary to build community awareness of it before trying to recruit the first group of advocates. This can be accomplished by working with other community organizations to familiarize them with the intervention goals. By doing this, you can enlist their support for publicizing your efforts. The second strategy involves working directly with community members to increase their awareness of your efforts. This allows you to gain their trust and to secure their endorsement of the program and its goals. The agency's outreach worker is invaluable in working directly with community members to establish a presence in the community. TA providers can be helpful with encouraging the agency to be creative about increasing the visibility of the program. Posters, flyers and other materials that bear the program name, logo and information are examples.

- *Identify recruitment areas.* The best recruitment areas are places where the target population naturally congregates. Methadone clinics, HIV counseling and testing centers, STD clinics, gay and lesbian community centers, coffeehouses, public cruising sites, and adult bookstores can be good places to initiate recruitment efforts. These locations can be identified by conducting interviews or focus groups with target population members or those who work with them. Once initial

advocates are recruited, they can also be an important source for identifying new areas and strategies for recruitment.

- *Recruit potential advocates.* Once Community PROMISE implementers know the type of persons they are looking for to be advocates (see above section on "effective" advocates), they can recruit persons in the field, through referrals or through announcements and advertisements posted in the community or targeted publications. The best locations for successfully recruiting advocates will depend upon the population targeted for intervention. The CID process will tell you where to begin and may have identified potential advocates already. Areas where population members naturally congregate—such as methadone clinics, gay and lesbian community centers, coffeehouses, public cruising sites, and adult bookstores—can be good places to initiate recruiting efforts. Locations for recruiting advocates may be identified during the formative research period through individual interviews or focus groups. Involving advocates in identifying new areas and strategies for recruiting new advocates can be helpful and can also increase an advocate's sense of involvement. Since you are trying to recruit advocates from a variety of networks you want to look at your CID results and determine what the agency/geographic/hangout/social networks are for your target population. Then you can begin recruitment to cover those networks. Recruiting people just through other advocates may restrict your coverage of networks.

Recruiting advocates from the field/street requires considerable trust building (see Section B: Conducting the Community Identification Process, Building Trust and Recruiting the Participation of the Community). Outreach workers should begin by introducing themselves and the project so that they are not mistaken as a "narc," some other official, or person selling drugs or sex. Several contacts may be made with potential advocates over time in the field to build trust and rapport and determine their willingness to disclose personal information and make a commitment to become involved with the intervention.

Outreach workers should describe the peer advocate work as an opportunity to do something good for the community and stress the importance of the peer advocate's role (e.g., saving lives, reaching people who may not get STD/HIV information otherwise). They should also describe the incentives that will be provided to advocates. After it has been determined that the field contact has a genuine interest, an outreach contact sheet should be completed (see Appendix R: Advocate Contact Sheet of the Community PROMISE Implementation Manual) so that the person can be contacted to schedule and participate in training.

As stated above, service providers, community leaders, gatekeepers, and recruited advocates can be important referral sources for identifying other potential advocates. Several

individuals with these categories may already be part of active networks of Community PROMISE implementers. Though they may be respected referral sources, it will be important to screen all potential advocates to assure that they fulfill the agency's selection criteria for recruitment of effective advocates.

Another method of recruitment is through advertising and announcements. Ads for advocates can be placed in newspapers or publications that are read by the target population, flyers can be posted at target population "hang outs," and recruiting materials can be placed in agencies that serve the target population. This method may be especially useful for recruiting populations that are not readily accessible on the streets or in specific venue, such as non-gay identified men who have sex with men.

- *Follow-up after initial recruitment.* Soon after recruitment, the advocates should be scheduled to take part in training and they should receive a formal written invitation either directly on the street or through the mail. Each person should be re-contacted and reminded a day before the training. Other methods that can be used to increase advocates participation in training include providing transportation or reimbursement for transportation costs.

Q. *What if a peer advocate engages in risk behaviors? What if he/she is in recovery? Can they still do effective work with the target population? How should we handle these situations?*

A. Advocates do not have to consistently use condoms, clean needles or engage in other risk-reduction behaviors. They do need to believe in the importance of protecting themselves from STD/HIV and at least be working toward their own consistent risk- reduction practices. For example, if an advocate is known by his or her peers as someone who refuses to use condoms, then he or she will likely not be a credible or effective advocate.

Advocates who are in recovery require special consideration. At times, people who have entered the recovery process can be judgmental of those who still use substances and these individuals cannot serve as effective advocates. For those who are not judgmental and are actively doing peer advocate work for the program, care should be taken to check in with them regularly to see how they are handling being in high-risk environments and whether their sobriety is being jeopardized. It is also important to note that advocates who are ex-addicts may be more credible in their work with the target population if they "step back" and deal with them not as a current user with the typical lingo, game and talk, but as an ex-addict who does not judge others behavior.

Effectively Training Peer Advocates

While there are great advantages to utilizing peer advocates to implement Community PROMISE, it is important that peer advocates

are consistently trained in effective techniques of distributing prevention materials so that the intervention can be implemented with fidelity. The TA provider can consult with Community PROMISE implementers by first reviewing the content for peer advocate training that is outlined in the Implementation Manual, encouraging the agency's investment in the training of advocates and responding to particular questions that staff may have about adapting training to agency circumstances and peer advocates' needs.

Here are some questions that Community PROMISE implementers may ask about training peer advocates.

Q. *How should we train our peer advocates? Is one training enough?*

A. The Community PROMISE Implementation Manual provides instructions and specific content for what should be included in an initial training of peer advocates. This material is outlined only briefly below with a more lengthy discussion about how advocates should be trained regarding material distribution and training activities that should be considered after an initial training.

Activities to Consider in Conducting an Initial Training

- *Pre-training tasks.* Folders for each training participant should be prepared that contain a training agenda, advocate contact sheet, advocate agreement form, map of the targeted intervention area, pen, and blank paper. A light snack or full meal for participants should be prepared. Newsprint containing basic STD/HIV transmission and prevention information should be prepared and placed in front of the room along with a TV monitor and VCR if a video will be shown.

- *Location of training.* Ideally, training should be done in a formal setting such as the agency that is implementing Community PROMISE (e.g., a CBO or local health department). It is helpful if the training can be done at a location that is easily accessible to the advocates and can be used later as a regular site for distributing prevention materials to the advocates. If the agency does not have room to do training, or considers another location to be more accessible to advocates, it may be beneficial to work out arrangements with a business interactor who is supportive of the project and who will allow use of a local storefront or recreation center for peer advocate training. Another option is to collaborate with another agency to share resources.

- *Introduction.* The training facilitator and frontline staff on the intervention should make welcoming remarks and introductions to the training participants. Past trainings of advocates for Community PROMISE have also given advocates an opportunity to meet other agency staff, including those who direct the agency, such as the Director of the Department of Health. Experience has shown that these introductions with key administrators, and even having photos taken with them, are

quite meaningful to peer advocates who feel that they are part of something that is important. Trainees should also introduce themselves and say why they are interested in being a peer advocate and perhaps review what past AIDS training they may have received.

- *Overview of the program*. Trainees should be provided with a description of the Community PROMISE, its purpose, source of funding, populations to be targeted, its emphasis on risk reduction and information on its successful use in other parts of the country.

- *Target area and target population*. The location of the target area should be described and located on a map and trainees should be provided with an explanation for why the target area was selected. The target population should be described and participants should be encouraged to distribute prevention materials only to those targeted for the intervention–not to everyone. Participants should be asked to think about people they know who are target population members as well as how they could identify additional members.

- *Importance and responsibilities of advocates*. All the various reasons why advocates are critical to the success of Community PROMISE should be emphasized with the training participants along with their responsibilities– distributing materials to the target population members, assembling materials for distribution, suggesting additional peer advocates, and restocking business advocate sites. Advocates should be reminded that they are volunteers and that it is all right if they want or need to stop their volunteer work. They can always restart as an advocate at another time.

- *HIV/AIDS information*. Basic HIV and AIDS information should be presented to the group. It is important that what is presented is tailored to the information needs of the group with the understanding that more knowledgeable advocates should receive more advanced information.

- *Role model stories*. The role model stories that will be distributed should be read out loud and reviewed with the participants. Trainees should be informed about how they were developed from target population members. Advocates need to understand how the stories have been written to advance target population members to the next stage of change related to their risk behavior. Although formal behavioral theory may not need to be reviewed with the advocates, the basics of theory should be reviewed in practical terms and language that are understood by the advocates. This is especially true of the transtheoretical or stages of change model, given its influence on the role model stories.

- *Material distribution*. Training advocates on effective methods of material distribution is the most important part of

the training. Advocates need to get across specific messages when distributing role model stories and need to be coached on how to respond to the various reactions that they will receive from people. Here are some points that should be emphasized in this part of the training:

a. Use a non-threatening approach. Advocates should approach people in the field in a natural way, using vernacular language and terms they normally use. If a target population member does not appear interested, the advocate should not be aggressive but should encourage the contact to give the information to someone who would be interested.

b. Discuss stories and important STD/HIV information. Rather than simply handing the field contact the role model story, the advocate should be instructed in how to talk to the contact about what is in the story, with special emphasis on the reason (i.e., influencing factor) why the person made some sort of risk reduction change. In addition, the advocate should be prepared to hand out risk reduction materials (i.e., condoms, bleach) and emphasize the importance of STD/HIV prevention.

c. Positively reinforce and follow-up. It is hard for people to change their risk behaviors, or even make progress toward this change. Advocates need to be instructed on how to give encouragement and reinforcement to their contacts when they see that progress is being made or maintained. They should also learn how to stay positive, even if their contacts have not made progress. Finally, advocates should be encouraged to follow-up with their contacts and check in to see how they like the material to reinforce the reading of the stories and practicing of the behaviors in the stories.

- *Role-playing*. Advocates should take part in role-plays of material distribution so that the techniques can be reinforced and they can receive important tips and feedback from the trainers/outreach workers.

- *Incentives*. If incentives will be used with the advocates, these should be reviewed, including the schedule and qualifications for receiving them.

- *Advocate responsibilities*. Advocates should be aware that they are obligated to follow certain rules or guiding principles for behavior while participating in the program. Training should address these principles and discuss processes for dealing with violation of principles.

- *Closing*. Participants should be asked to decide whether they are willing to make a commitment to become an advocate. Those who are willing should be given instructions about the next steps in carrying out the intervention. The facilitator should read aloud the advocate

agreement form, and clarify any questions and ask all who want to be a peer advocate to sign the form.

Further Training of Peer Advocates

Those who have implemented Community PROMISE emphasize that the training of advocates should be an ongoing, never-ending process. Although agency staff may have been doing prevention work for many years, it should be recognized that many advocates may be receiving new information during their initial training and that only a certain percentage of it will be retained. Therefore, several other opportunities should be provided for learning and skill enhancement.

After the recruited advocates complete their initial training, the next recommended step is field training. Advocates can observe outreach workers doing material distribution and outreach workers can observe the new advocates' distribution techniques and make any necessary corrections or feedback. Once in the field, advocates can be encouraged to attend training update sessions. New advocates are asked to keep track of the questions that have come up as they are doing their work and to bring the questions to the update sessions. These sessions are spent responding to questions and enhancing their knowledge and skills.

Doing ongoing training of advocates can often be a challenge in that many of them may be "doers" and may not have the time, patience, or understanding of why substantive training is necessary. Past implementers of Community PROMISE have been creative in encouraging advocates to participate in ongoing training. In Long Beach, for example, advocates were invited to a social event into which role-playing exercises were integrated.

Q. *What if some peer advocates do not have time to be trained?*

A. Various aspects of Community PROMISE should be adapted to respond the circumstances and needs of the implementers and the communities that are being served. In certain circumstances, potentially effective advocates may not be able to attend the initial training but could still do some important work for the program. Past implementers of Community PROMISE in Dallas, for example, experienced this situation. Though potentially effective advocates could not attend a scheduled training, they were intent on attending a later training and were enthusiastic about distributing prevention materials immediately, including at upcoming parties where they knew high-risk activity would be happening.

These advocates were called "shotgunners" and the Dallas Community PROMISE implementers conducted shortened 20-minute trainings in the field for such individuals wherever they were–on the street, in a bar, or in a laundromat. Agency staff then gave them role model stories and prevention materials and encouraged their continued involvement and participation in a later training. Although such an approach was not ideal, it was recognized that "shotgunners" had the potential for reaching the target population and such an adaptation of the initial training

model was necessary in these circumstances. Staff also felt that even if they never saw these advocates again, the advocates might share the prevention material with members of the target population.

Q. *What if our peer advocates do not have an expert grasp of facts related to STD/HIV/AIDS. Can they still be effective in the field?*

A. Yes. Information about STD/HIV/AIDS is shared with peer advocates during training, but it is not expected that all advocates will have an expert grasp of the information when they do their fieldwork, especially if the information is relatively new. The major role of a peer advocate is to establish connections with the target population, distribute prevention materials, and influence and reinforce behavior change among their peers in places and at times that may be prohibitive for agency staff. If advocates are asked questions in the field about STD/HIV that they cannot answer, it is acceptable for them to plead ignorance, find out the correct answer, and get back to the field contact with the pertinent information.

D. Developing Role Model Stories

One of defining characteristics of Community PROMISE is its use of role model stories that describe the experiences of target population members in their efforts to reduce risk behavior. The effective development and dissemination of these stories is the intervention's main strategy for motivating the target population toward the desired behavioral goal. The process of developing role model stories in a way that resonates with the community and motivate behavior change can present challenges for Community PROMISE implementers. In addition, producing them in a cost-effective way with an appealing format presents additional challenges.

Because most ASOs make it a priority to distribute information on the ABCs of STD/HIV transmission and prevention, Community PROMISE implementers may need help in understanding that the intervention has a different approach. Role model stories are not intended to provide factual information on STD/HIV/AIDS. Rather, their intent is to motivate, encourage, and reinforce behavior change that will prevent the transmission of STD/HIV.

TA providers can provide assistance to Community PROMISE implementers in several areas related to role model stories. Implementers may need help in identifying appropriate role models to interview as a source of the stories and require assistance in understanding how many interviews are needed to sustain their program. They may also ask for assistance in efficiently and effectively conducting role model interviews once they have recruited appropriate role models. Another substantive area can be helping them take an abundance of interview data and effectively using them in a role model story. Along this line, Community PROMISE implementers may need feedback on how to write and develop a role model story so that the role models themselves are protected

from adverse consequences. Further, it may be unclear to Community PROMISE implementers how many different role model stories an agency will need to produce for distribution purposes, or how they can develop and produce role model stories in line with their fiscal constraints.

This section contains information TA providers need to help Community PROMISE implementers develop role model stories with fidelity. It contains questions and answers related to three issues that were identified during field testing:

- Conducting role model interviews
- Writing role model stories
- Producing role model stories

Conducting Role Model Interviews

If Community PROMISE implementers have decided to write their own role model stories, this requires that they recruit and interview appropriate role models from the community. Based on field experience with implementing Community PROMISE, it has been found that individuals from the target population are often quite motivated in wanting to be interviewed for role model stories. They have often worked hard to make changes in their lives, care about their community, and want to help members have a better life than what they have experienced. Not every target population member will serve as an appropriate role model, however, and agency staff may need guidance in formulating criteria for identifying and recruiting role models. Further, TA providers can provide assistance on the interview process itself and help Community PROMISE implementers determine how many interviews they need to conduct for their program.

Here are some questions that Community PROMISE implementers may ask about conducting role model interviews:

Q. *Who makes a good role model?*

A. Finding good role models starts with first identifying the targeted community and its members. More specifically, it requires that the objectives of the CID process are met. They are to identify:

- The population that will be targeted for Community PROMISE.
- Its risk behavior(s).
- The stage(s) of behavior change that the majority of the target population is currently experiencing *(i.e., pre-contemplation, contemplation, preparation, action, maintenance)*.
- The risk reduction goals that the intervention hopes to meet (*e.g., those related to abstinence; condom use for oral, anal and vaginal sex; safer injection practices; responsible use of alcohol; and other related behaviors)*.

In addition, the CID process, through its data collection from internal and external agency staff and from interactors, gatekeepers and target population members themselves, will

also assist Community PROMISE implementers to identify individuals who are starting to make changes in their risk behaviors and may be motivated in wanting to share their stories and help their community.

Good role models do not have to practice the risk reduction behavior perfectly. For example, they are not only the individuals who use condoms 100% of the time. They are also those who have only started using condoms, or who have used them with one partner or one type of partner. A good role model is someone from the target population who has made a positive change regarding the specific behavior to be modeled.

In order to recruit good role models, it is helpful to interview individuals from the target population and screen them with certain criteria. In addition to agreeing to formal protocols of being interviewed for a role model story, a potential role model should also meet the suggested criteria listed below.

- *The "fit" of the experience*. The role model's experience should "fit" with target goals of the role model story – the appropriate stage of change of the targeted behavior. If the role model, for example, is in the pre-contemplative stage of considering a change in their risk behavior but the CID process has found that the majority of the target population has moved toward the preparation stage, than this individual may not be an appropriate role model to interview for a story. Role models who focus on giving testimonials of what they did wrong are also not appropriate since they do not provide useful information about positive changes that have been made.

- *Risk-reduction is associated with STD/HIV prevention*. A potential role model should be motivated in practicing risk reduction behavior, or intend to do so, and the motivation should be associated with reducing the risk of STD/HIV infection—not another motivation, such as pregnancy prevention.

- *Recall and ability to share*. Potential role models should be able to recall and describe specific details about past and present risk and goal behaviors as well as be willing to openly share their stories during an interview.

One adaptation that has been made in the field regarding role model interviews has been the interviewing of outreach workers instead of community members. This has often taken place initially to facilitate getting the Community PROMISE out in the community in a timely fashion. The most important advice that TA providers can give Community PROMISE implementers related to this adaptation is that it is quite important that the stories of outreach workers actually reflect the larger community where the intervention is taking place.

Q. *What incentives should I give to role models who participate in interviews?*

A. As stated previously, members of the target population for Community PROMISE are often highly motivated to tell their stories and, thus, may not require incentives. However, if the budget allows, it is important that at least transportation costs are covered if an individual needs to travel to a specific site to be interviewed. Providing incentives to the role models is a sign of respect for valued information and it can increase cooperation.

To identify what incentives would be most appreciated by target population it can be helpful to conduct a focus group of eight to ten individuals. Decisions related to incentives may be affected by agency or funder policies, such as prohibiting the use of cash incentives. Field experience has shown that along with cash, other successfully used incentives have included: 1) food (at the interview site); 2) coupons to local stores such as KMart, WalMart, McDonalds, Home Depot (these can often be donated by these companies); 3) cosmetics for women or hygiene kits for sex workers; and 4) and small gifts such as T-shirts, backpacks, or other items that display the logo of the program.

Q. *How many role model interviews should I conduct?*

A. Reports from the implementation of Community PROMISE during its initial field testing in Long Beach showed that 70 individuals were interviewed for their stories over a 3-year period. Overall, at past interventions sites, role model interviewing has taken place on a weekly basis as the project was carried out.

Providing TA advice on the number of interviews that should be conducted by Community PROMISE implementers depends on a number of factors. Role model interviews are conducted to produce information for role model stories. To identify how many interviews to conduct it is helpful to understand how many role model stories will be needed for the effective implementation of Community PROMISE in a particular community. Role model stories need to be simple—addressing one particular risk behavior, stage of change, and influencing factor. If the target population is engaging in multiple risk behaviors and several factors are influencing change, it will be important to have multiple stories that address these behaviors or influencing factors. This way, when role model distribution is being conducted in the field, staff or peer advocates will have an assortment of stories to choose from, depending on the needs of a particular contact.

Staff or peer advocates will also have repeated interactions with the same target population members. In these circumstances, it is useful to provide different role model stories to maintain their interest in the intervention and its goals. In addition, as the intervention is carried out over time, evaluation activity may determine that the target population overall has moved into a different stage of change. This factor would necessitate the production of other role model stories that would motivate a more advanced stage of change among target population members.

Fortunately, field experience has shown that the dialogue from one single interview can be so rich that it often generates enough information for several role model stories. In the example of the Long Beach demonstration site, the 70 interviews that were conducted with role models yielded 119 stories. One individual may discuss several stages of change that they have accomplished over their life related to one or more risk behaviors. In addition, one interview may reveal several influencing factors over a period of time that motivated the interviewee's risk behavior change. Past Community PROMISE implementers have creatively developed a series of stories from one individual through his or her behavior change process.

Writing Role Model Stories

Writing role model stories from the interview data can be a challenging task for Community PROMISE implementers. Formal training will have emphasized that eight elements should be included in a role model story. These are:

- Characterization
- Membership in target population
- Risk behavior
- Goal
- Stage of change
- Influencing factors
- Barriers to change and methods to overcome barriers
- Positive outcome

TA providers can help agency staff sort through their interview data and effectively use them to address these eight elements and write a story that effectively resonates with the target population. For those Community PROMISE implementers who may not have enough original material to write role model stories, TA providers can also provide assistance in adapting existing stories for use with the particular community.

Here are some questions that Community PROMISE implementers may ask about writing role model stories:

Q. *Several other agencies have developed role model stories related to our target population. Can't we just use these?*

A. Every agency or group of agencies that decide to implement Community PROMISE will need to make decisions about how to effectively use their resources to design, implement, and evaluate the intervention. The Community PROMISE Implementation Manual has suggested that there are Good, Better, and Best ways of developing role model stories. Using existing role model stories from other locations is considered a Good option. Its limitation is that these stories do not contain references to the local community and the target population members may not relate closely to them. A Better option is to use a previously produced role model stories and add local references or "flavor" to them, such as local landmarks or phrases used by the target population. Developing your own role model stories, the Best option, will ensure that your program is relevant and sensitive to the population you target.

It has been found that previously written role model stories are often used or adapted when agencies are first starting out and do not have

much access to role models. Community PROMISE implementers at this early stage may have limited experience with the community and may not as yet have built sufficient trust with target population members. Although using existing role model stories may be an acceptable way of implementing Community PROMISE initially, TA providers may want to encourage implementers to eventually gather role model stories on their own communities. Doing so requires practice, but the act of connecting with the community, engaging them in the interview, and disseminating the stories back to them, can allow for considerable target population "ownership" of Community PROMISE. One way for an agency to reduce the costs of developing original role model stories is to collaborate with other agencies to implement Community PROMISE and share these costs.

Q. *Should we identify the actual individual in a role model story and use a photograph to make it more authentic?*

A. TA providers may want to review past practices with Community PROMISE implementers so they can help agencies make informed decisions. The issue of identifying actual role models in stories and using their photograph was handled differently across sites in the original implementation of Community PROMISE. Though role models often wanted their names and photos to be used, this was rarely the practice in Long Beach and Denver. In addition to not using names or photos, other protective practices were used in Long Beach. Certain pieces of information were changed in the story if it was felt that an individual could be identified in the larger community (i.e., a story was written about a role model who had six children when in fact she had eleven). In addition, the interviewer always recorded the real name and any nicknames of the interviewee to ensure that the fictitious name used in the story was not the actual name of the role model. The rationale for these protective practices was that if real names were used and at a later time, the individual changed his or her mind about having this information public, the information would have already been disseminated and the situation could not be rectified.

In Dallas this issue was handled quite differently—the decision was left up to the role model. Photos, names, and actual information from the interview were used or not used depending on the preference of the role model at the time of the interview.

Q. *We have used vernacular language in our role model stories and the Material Review Panel will not approve them. What should we do?*

A. If the Panel does not approve the stories, they cannot be used as written. In these situations, it is best to identify exactly what language in the story is objectionable and revise the language in such a way that it can be approved and still be understood by target population members.

Again, it may be helpful for the TA provider to review how past Community PROMISE implementers have effectively worked with Material Review Panels. In Long Beach, for

example, Community PROMISE implementers worked very closely with the Department of Health to have input on who served on the Material Review Panel. In addition, panel members were assured that controversial materials were only distributed one-by-one to target population members and were never left in stores or other public venues for mass consumption.

Producing Role Model Stories

Past implementation of Community PROMISE has shown that there has been considerable creative adaptation of the intervention when it comes to producing role model stories. Community PROMISE implementers will vary considerably in regard to the resources they have to produce stories as well as the needs of their target population for accepting and using the information in the stories. TA providers should encourage implementers to get input from the target population about how the stories should be produced and, once produced, how they might be improved for maximum appeal in the field. Community PROMISE implementers may need assistance on knowing how many stories to produce as well as how to do so in a cost-effective manner.

Here are some questions that Community PROMISE implementers may ask about producing role model stories:

Q. *How many role model stories should we produce?*

A. Past implementers of Community PROMISE have developed and produced new role model stories between every two weeks to one month. In Long Beach, for example, the publication "Road Dogs" for drug users and "For Women Only" for high-risk women (female sex partners of male IDUs, sex workers) were initially produced once a month. However, implementers received feedback from the target population that the publications came out too seldom. Production, therefore, was increased and publications were distributed twice a month, for a total of 119 new stories produced over three years.

Providing advice as a TA provider on the number of stories that Community PROMISE implementers should produce depends on a number of factors. As stated above, if the target population being served by Community PROMISE is engaging in multiple risk behaviors and several influencing factors affect change, it will be important to have several stories produced that address these behaviors and influencing factors. This way, when role model distribution is being conducted in the field, staff or peer advocates will have an assortment of stories to choose from, depending on the needs of a particular contact.

As discussed previously, it is useful to provide different role model stories to individuals with whom peer advocates have repeated contacts, in order to maintain their interest in the intervention and its goals. Producing new stories is also necessary as you identify that your target population has moved to a different stage of change.

***Q**. We don't have a lot of resources to produce our role model stories. What would you suggest?*

A. You do not need a lot of resources to produce role model stories. Some agencies may be able to afford color laser printing and use professional artists to produce the stories, but this is not necessary. Agencies have found that black and white photocopies of the stories containing local artwork may be more appealing to the target population and less costly to the program. Community PROMISE implementers have also found that using two-color printed material produced at a local copy shop is relatively inexpensive. In addition, word processing software usually has a wide assortment of graphics that can be downloaded for use. The most important issues to keep in mind in producing role model stories is that they should provide clear program recognition and reflect the cultural nuances of the intended audience.

To understand what is culturally relevant and appealing, it is important for Community PROMISE implementers to learn from the target population. For example, one agency expected to produce a large, newspaper-style publication, but found from their target population, who were hustlers, that they would be more satisfied with a story on a card that could be stuck in their back pocket along with hygiene materials that could be donated by local vendors.

The sites that implemented Community PROMISE under CDC's AIDS Community Demonstration Project had sizable resources to produce their materials. Some agencies who have reviewed these materials may feel that production costs would be prohibitive for them to consider implementing Community PROMISE. TA providers need to help Community PROMISE implementers recognize the value of low-cost production options, help implementers review these options in light of available resources and encourage the contributions of the target population in helping make decisions. In addition, TA providers can assist the agency to identify possible community collaborators on Community PROMISE who may be willing to share the costs of the production of the role model stories.

E: Distributing Role Model Stories and Prevention Materials

Once the role model stories have been produced, Community PROMISE implementers will need to make a plan about how to distribute them and how many can be effectively distributed. TA providers can help Community PROMISE implementers grapple with these issues and provide advice about the appropriate prevention materials to distribute with the role model stories. TA providers can also assist Community PROMISE implementers decide who should distribute the materials–outreach workers, peer advocates, and business advocates–and how these individuals can best reach the target population. Role model stories can be offensive to some people in the community, especially those not in the target population,

and Community PROMISE implementers should be advised on distribution methods so this effect is minimized.

This section contains information TA providers need to help Community PROMISE implementers effectively distribute role model stories and risk reduction materials to the target population. It includes questions and answers related to three issues that were identified during field testing:

- Essentials of peer advocate distribution
- Tips for effective distribution
- Challenges with distribution

Essentials of Peer Advocate Distribution

Effective material distribution is essential to the success of Community PROMISE. Even though Community PROMISE implementers may have developed, produced, and packaged culturally appropriate materials for distribution, if the target population is not consistently reached with these materials and not encouraged and provided reinforcement to change their risk behaviors, these efforts will not pay off. TA providers can support agency staff in their efforts to design and carry out an effective distribution plan.

Here are some questions that Community PROMISE implementers may ask about essentials of peer advocate distribution.

Q. *Who, ideally, should our peer advocates try to reach?*

A. If Community PROMISE implementers have been able to recruit the right peer advocates, these individuals should have easy access to several social networks in the population that have been targeted for the intervention. These advocates can regularly distribute the materials in their natural living patterns, whether that is during individual contact with members of their social network or in a group environment, such as at a party, in a bar, or in a drug shooting gallery. Peer advocates also can distribute materials to target population members outside their social networks, but this may not be as effective. The advocates' personal connection to the members of their social networks and network members' acceptance and respect for advocates can more effectively enhance the impact of the intervention than when there is no direct link.

Enough peer advocates should be recruited to effectively reach the various locations frequented by the target population. As part of appropriate program management, a distribution plan should be developed that includes a map of the targeted area and a dot where each advocate has network contacts and can effectively work. If parts of the mapped target area do not have coverage, other advocates will need to be recruited to increase coverage.

Q. *In addition to role model stories, what prevention materials should be distributed?*

A. To identify what prevention materials should be distributed with the role model stories, it is important to receive the input of the target population and those prevention staff who work directly with them. This can be accomplished by conducting focus group or individual interviews. Most importantly,

materials that accompany role model stories should be tailored to the needs of the population targeted by the publication. For example, if sex workers are targeted, packets should include non-lubricated condoms (preferred for oral sex) as well as lubricated ones. For men who have sex with men (MSM), it is important to include lubricant along with condoms. Materials on the correct use of condoms should also be included as well as information on referrals for services that respond to the broad needs of the target population, such as employment, immigration, legal, mental health, drug treatment, and medical services.

In Long Beach, the Community PROMISE intervention distributed packets that responded to the needs of the different target populations. Condom packages for sex workers included three condoms–mint-flavored, lubricated, and non-lubricated. IDUs were given packets containing: one-ounce bottles of bleach with leak-resistant caps and instructions for use printed directly on the bottles (self-stick labels with instructions can also be used), one-ounce bottle of water (to use with bleach), and one cotton ball (often used as a filter through which an IDU can draw up the dissolved drug into the syringe). They were also offered two condoms, which were considered a sufficient number based on information from the target population.

Q. *On average, how many stories/materials should a peer advocate expect to distribute per week?*

A. In past implementations of Community PROMISE, each advocate has been given 10 to 20 packets of materials each week or two to distribute to members of the target population. The agency should keep a record of what materials are distributed to advocates or outreach workers (whoever is doing field distribution) on a weekly basis. This component of the "distribution plan" is used to estimate the number of publications to print and the amount of other material to purchase (such as condoms, lubricant, bleach, water bottles, and plastic bags). Plans should include the number of individuals (staff, peer advocates) who will be distributing the material, the estimated size of the target population, and where and how often the material will be distributed. They should also take into consideration the frequency of publication production (bi-weekly, monthly, or quarterly). Various factors can influence the production of materials (e.g., a less expensive paper might need to be used in order to produce the number of publications needed) and vice versa.

Q. *Besides peer advocates, who else could distribute our role model stories?*

A. Business advocates can also help with distribution of role model stories. These individuals, also known as interactors, can be approached during the CID process because they often have regular contact with members of the target population. Examples include a

beautician at a beauty parlor, a merchant at a liquor store, or a clerk at a motel–people who interact with the target population in the course of their business.

For example, an owner of a local liquor store located in the area where sex workers solicit clients could give out condoms to the women who come in the store and encourage them to read the role model story publication. They can also display posters or other prevention materials for the program. The participation of business advocates can provide the target population with regular and consistent access to prevention materials at a known location. It requires minimal effort on their part, yet it increases the visibility of the program. However, it is important to note that although business advocates can supplement the work of peer advocates, they should not replace them.

Tips for Effective Distribution

To effectively distribute role model stories in the field, staff and/or peer advocates need to interact with their contacts so that the stories can have their maximum effect. Simply handing the materials to members of the target population without understanding their needs, encouraging their risk behavior change, or checking in with their progress, will not be effective. Based on what has worked well in the field, TA providers can give Community PROMISE implementers important tips to make their distribution strategies more effective.

Here are some questions that Community PROMISE implementers may ask about distribution strategy:

Q. *What if our peer advocates see certain target group members regularly in the field. Do they give these target group members the same role model story?*

A. If the members of the target population have shown an interest in the role model story publications that are being distributed, they will want to see new stories on a fairly regular basis. Handing out the same stories over time can cause people to lose interest in the intervention and be less motivated to change their behavior or maintain the changes they have made. Although it may require more work of the Community PROMISE implementers to produce more stories, the effort can have a positive effect on individuals that staff or peer advocates may see regularly in the field.

Q. *What if we find out that over time our target population is progressing along the continuum of stages of change. Should we change our approach? If so, how?*

A. The goal of Community PROMISE is to encourage the community to change behaviors in ways that will help prevent STD/HIV. The CID process will assist Community PROMISE implementers to identify what initial stage or stages of change the target population members are in with respect to their risk behaviors. In contrast, the program's evaluation outcome monitoring efforts should try to periodically assess whether the population has progressed along the stages of change continuum. If the evaluation reveals that overall progress has been made, or, if staff or advocates can determine that specific individuals have progressed in this way, then

the distribution of different stories, reflecting a higher stage of change, should be offered to the field contacts. TA providers should advise agency staff that Community PROMISE is a dynamic intervention that requires implementers to regularly assess the needs of the target population and respond accordingly.

Challenges with Distribution

The success of Community PROMISE depends on agencies implementing its four core elements with fidelity while at the same time tailoring and adapting these elements to the needs of the target population and the circumstances of the community. When it comes to effective distribution of prevention materials, this means that Community PROMISE implementers need to identify the best ways to reach the target population and communicate the stories and their prevention messages. With some populations, this can present challenges. TA providers should be prepared to address this issue with agency staff and, together with members of the target population, creatively identify solutions.

Here are some questions that Community PROMISE implementers may ask about challenges they face with the distribution of prevention materials:

Q. *What are the some of the different ways that role model stories can be distributed to effectively reach the target population?*

A. In order to reach different target populations, several Community PROMISE implementers have created a wide assortment of methods to distribute role model stories. During their CID process, they learned from the target population what would work best for them. Community PROMISE implementers have put in a considerable amount of "up front" work to identify not only what is initially appealing but also what keeps their interest over time, namely what "hooks" them into wanting to read more stories. Several examples are provided below.

- Some populations, including those with literacy issues, or Native Americans who have oral traditions, prefer to hear the role model stories rather than read them. This has resulted in the use of street-based theatre, group story-telling, radio spots, and cassettes of role model stories played in places where the target population gathers.

- In Oklahoma City, Native Americans were effectively reached by distributing role model stories on the back of paper fans that were used at pow-wows.

- Role model stories for gay men have been printed on posters displayed in restrooms.

- In one program, target population members received free phone calling cards that gave them access to a voicemail system where they and their contacts could leave messages. Each time they used the system, they would also hear a role model story. In another program, role model stories were put on a hotline used by the target population. Role model stories have also been used on Internet chat rooms.

- In West Dallas, the target population preferred receiving a small newspaper tabloid that not only had role model stories but things they requested like recipes, personal ads, and birthday wishes.

- In a program in New Mexico, migrant farm workers preferred a series of soap-opera stories in which the same characters appeared repeatedly. The workers looked forward to seeing how their lives had changed.

Q. *We are facing challenges with trying to reach our target population who are non-gay identified MSM. What would you suggest?*

A. Community PROMISE works best when it is implemented with high-risk individuals who are part of social networks–a structural factor that naturally facilitates the dissemination of prevention messages in a community. Though IDUs and other high-risk individuals are usually part of close social networks, other high-risk individuals may not be as visibly connected. This can be the situation with non-gay identified MSM who don't connect with the gay community. If they do have social networks, these networks are often hard to reach.

Experienced Community PROMISE implementers have concluded that a network exists within any target population–you just have to find it. With non-gay identified MSM, the use of peer advocates is especially critical in order to reach their networks. Their networks may function in places they go for sexual encounters and social mingling, Internet chat rooms, or other environments where their privacy can be assured. Using strongly gay-identified outreach workers or advocates and disseminating stories that have gay themes in them will not be appealing to this population, and Community PROMISE implementers need to be sensitive to these issues. "Snow-ball" recruitment can be effective by connecting with members of the target population one at a time. Initial contacts can offer referrals to others so that eventually a core group of non-gay identified MSM can both advise the agency about how Community PROMISE materials can be best disseminated as well as reach other men in their differing networks with the Community PROMISE prevention materials and message.

F. Evaluating the Intervention

Evaluation is one of the four core elements of Community PROMISE, and a key program management tool for this or any other behavioral intervention. Program evaluation is essential for accountability to the funding agency, project staff, and clients. It is also necessary for quality assurance and program improvement, and for knowledge development as it relates to planning future programs. As an effective, science-based intervention, the correct and efficient implementation of Community PROMISE relies on adherence to the evaluation protocols.

Agencies evaluating Community PROMISE are asked to perform the following types of evaluation:

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[1] Rogers Everett M., "Diffusion of Innovation", 4th edition, *Free Press*, NY, 1995.

- Formative evaluation
- Process monitoring
- Process evaluation
- Outcome monitoring

Below are some questions agency staff may have while planning and conducting evaluation activities:

Q. *What is formative evaluation? How and when can my agency begin conducting formative evaluation?*

A. Formative evaluation involves collecting and analyzing data that describe the needs of the target population, the factors that put them at risk, and factors that can help them reduce their risk and protect their health for the purpose of developing or implementing the intervention in the most effective manner. In Community PROMISE, formative evaluation is accomplished by conducting the CID process. The methods to assist agencies in this process include: surveying internal staff, surveying external sources systems, making community observations, interviewing interactors, key observers, and gatekeepers, key participants, and conducting focus groups of risk population members (see Appendix B: Implementation Steps). Formative evaluation can also include pretesting role model stories with the target population before they are formally used in the field.

Q. *What are the differences between process monitoring and evaluation, and outcome monitoring and evaluation?*

A. These terms represent four distinct types of evaluation practices. Agencies implementing Community PROMISE need to conduct process monitoring, process evaluation, and outcome monitoring. The data and information resulting from these evaluation procedures are sufficient to satisfy most evaluation requirements from funding agencies.

Process Monitoring: An agency conducts process monitoring by documenting and analyzing the way the program operates, including collecting data that describe the characteristics of the population served, the services provided, and the resources used to deliver those services.

Some of the questions answered by process monitoring are: What program activities were conducted? What services were delivered to whom? When and how often? What resources were used?

Examples of process monitoring activities for Community PROMISE include: keeping track of the number and type of interviews conducted during the CID process, documenting the number of peer advocates recruited and trained, and keeping a log of the number of role model stories produced.

Process evaluation: This involves collecting and analyzing data about how the intervention was delivered, whether it reached the intended audience, and how the intervention was accessed.

Questions answered through process evaluation include: Was the intervention implemented as intended, and with fidelity to the core elements? Did the intervention reach the intended audience? What barriers did outreach workers or advocates experience in accessing the target population?

More specifically, process evaluation can help staff assess detailed and qualitative aspects of program components, such as whether the role model stories developed are stage-specific, or if peer advocates were identified from each social network. Process evaluation can also help link activities to objectives, for example, assessing whether the planned number of materials were distributed or if sufficient networks were identified to cover target population.

Outcome monitoring: This involves collecting data about client (target population) outcomes, before, during and after the intervention, such as behaviors, influencing factors, or intentions for behavior change. It can help determine if the intervention is meeting its objectives. It can answer the question: Did the expected outcomes occur? Outcome monitoring is done only after the process evaluation has shown that the intervention is being delivered as planned–when the intervention is "mature." However, it must be started beforehand in order to compare the outcome data with pre-intervention data collected as part of the formative evaluation. Outcome monitoring answers questions as: Did target population members exhibit a progression along the stages of change? Were there measurable changes in the influencing factors?

Outcome evaluation: Outcome evaluation collects data about outcomes before and after the intervention for clients as well as with a similar group (i.e., comparison/control group) that did not participate in the intervention being evaluated. It can answer the question: Did the intervention cause the expected outcomes?

Agencies are not required to conduct outcome evaluation because it would require a high level of technical expertise and resources. The original research and published reports proved the effectiveness of Community PROMISE.

Q. *How can my agency create an evaluation plan?*

A. An essential element in planning an evaluation is the program's logic model. Creating a logic model of the Community PROMISE intervention can greatly assist agencies in developing an evaluation plan. Logic models attempt to use words and/or pictures to describe the sequence of activities thought to bring about change and the chain of reasoning about how these activities are linked to the results the program is expected to achieve.[2] They can provide a clear description of the program and will help you identify the critical questions for your evaluation. A logic model can be a diagram, flow sheet, or some other type of visual schematic that conveys relationships between five essential aspects of your program and what you hope to achieve. Each is described below.

1) **Inputs.** Inputs are the program resources such as human, financial, organizational and community resources that are directed toward doing the work.
2) **Activities.** Activities are what the program does with its resources or the processes, tools, events, technology, and actions that are an intentional part of the program.
3) **Outputs.** Outputs are the direct products of program activities, including the types,

[2] W.K. Kellogg Foundation (2003). *Logic Model Development Guide*. Battle Creek, MI: W.K. Kellogg Foundation.

levels, and targets of services to be delivered by the program.

4) **Outcomes.** Outcomes are the expected changes in program participants' knowledge, attitudes, skills, behaviors, status, or level of functioning that result from program activities and are most often expressed at an individual level. *Short-term outcomes* should be attainable within 1-3 years; *longer-term outcomes* should be attainable between 4-6 years.

5) **Impact.** Impact is the fundamental intended or unintended change occurring in organizations, communities or systems as a result of program activities within 7-10 years. Impact often occurs after the conclusion of project funding.

Below, a sample logic model is provided for a "generic" Community PROMISE intervention that describes program inputs, activities, *outputs*, short-term outcomes, longer-term outcomes and impact. In regard to the four types of evaluation described above (i.e., process monitoring, process evaluation, outcome monitoring, and outcome evaluation), the logic model aids evaluation planning and implementation by describing: 1) the program outputs and the relevant indicators that can be measured during process monitoring and evaluation; and 2) *short-term and longer-term outcomes* and the relevant indicators that can be measured during outcome monitoring.

Sample Logic Model for Generic Community PROMISE Intervention

Inputs ➡	Activities ➡ *See Appendix B*	Outputs ➡	Short term outcomes ➡	Longer term outcomes ➡	Impact
➡ Full-time and part-time staff ➡ Peer advocates ➡ Collaborative agencies ➡ Intervention manual and TA guide ➡ Office space ➡ Equipment ➡ In-kind support ➡ Funding	➡ Market intervention ➡ Form advisory board ➡ Prepare for CID ➡ Conduct CID ➡ Use CID data to develop intervention ➡ Design evaluation and materials ➡ Recruit and train staff and advocates ➡ Recruit, screen and interview role models ➡ Write and produce role model stories ➡ Gain approval for all materials created and the intervention from your local health department's program review panel ➡ Package and distribute outreach material ➡ Nurture and support advocates	➡ Number and type of agencies, people reached with marketing efforts ➡ Number and type of methods used in CID and people reached ➡ Number and type of staff and advocates trained by type of training ➡ Number and type of role models recruited, screened and interviewed ➡ Number and type of stories written and produced ➡ Number of outreach packets developed and distributed ➡ Number and type of advocate incentives distributed	➡ Increased percent of target population who read/hear role model stories ➡ Increased HIV-related knowledge, attitudes, skills, intentions within target population ➡ Increased percent of target population who progress to next stage of change	➡ Increased percent of target population who change risk behavior, engage in protective behavior	Reduced HIV incidence/ prevalence in the community

A note on outcomes: Because the theoretical framework for Community PROMISE is based on the Stages of Change Theory, outcomes can be measured by how well the target population progresses along the stages of change continuum. Such progress does not necessary need to reflect that the population has progressed to the "action" stage when risk behavior change is initiated. If, for example, the target population is at the contemplative stage and moves to the preparation stage, while most may not have changed their risk behavior, they have still demonstrated progress and achieved an important outcome. Since many Community PROMISE implementing agencies will not have funding to conduct a longitudinal study, measuring the progression to the next stage of change is difficult. However, agencies can describe what percentage of the target population is at each stage of change at various points of time to determine to what extent that population has moved from one stage to the next. .

Below is a list of resources on logic models:

- United Way, Program outcome model, In *Measuring program outcomes: a practical approach*. *http://national.unitedway.org/outcomes/library/pgmomres.cfm*

- University of Wisconsin, Cooperative Extension (1998). Logic model: Your map and model of action, In Section 2 of *Evaluating Collaboratives*. Pp.22-30. http://cf.uwex.edu/ces/pubs/pdf/G3658_8.PDF

- W.K.Kellogg, W.K. Kellogg Foundation Logic Model Development Guide (2001). http://www.wkkf.org/Programming/ResourceOverview.aspx?CID=281&ID=3669

Once the logic model is articulated, agency staff can proceed to develop a formal evaluation plan and identify what data collection methods will be used to measure outputs for process monitoring and process evaluation (i.e., the use of documentation systems, logs, attendance sheets, observation forms, client feedback forms), and determining who is responsible for the data collection, when these data will be collected, and how they will be reported. Data collection methods for outcome monitoring also should be determined, such as the use of interviews/ surveys that collect the same data collected at baseline during the CID process. Overall, an evaluation plan should describe all the data required to do the evaluation and related tasks (including data collection, management and reporting), the resources to complete the work, and how these pieces are linked together.

The table on the next page demonstrates an example of an evaluation plan for conducting process monitoring of specific peer advocate activities.

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[2] W.K. Kellogg Foundation (2003). *Logic Model Development Guide*. Battle Creek, MI: W.K. Kellogg Foundation.

Sample Evaluation Plan for Process Monitoring of Peer Advocate Activities

Activity	Outputs	Data Collection Methods	How used	Staff Responsible	Schedule for Data Collection
Type of Evaluation: Process Monitoring					
Peer Advocate Recruitment	➡Number and type of referral contacts for advocates ➡Location and dates of recruitment ➡ Number and type of advocates approached and recruited	Peer Advocate Recruitment Log	Assess effort expended for number of advocates recruited; plan staffing and time allocation	Staff A, Staff B	01/01 to 03/31
Peer Advocate Training	➡ Number and type of trainings conducted; dates ➡ Number and type of advocates invited and trained ➡ Number and type of training materials distributed ➡ Number and type of incentives distributed	Advocate Recruitment (Training) Report	Track training activities; monitor performance of trainers and advocates; plan for future recruiting efforts	Staff B, Staff C	01/15 to 06/30
Peer Advocate Follow Up and Tracking	➡ Schedule and dates of peer advocate contact ➡ Number and type of packets/ materials distributed per peer advocate ➡ Number and types of community members reached per peer advocate	Advocate Contact Tracking Form	Assess peer advocate level of activity; yield of materials distributed; plan/modify training efforts, materials development	Staff A, Staff B, Staff D	01/15 to end of project period

Below is a list of evaluation resources:

- Handbook: Strategies for Implementing the Evaluation Guidance for CDC-Funded HIV Prevention Programs, Centers for Disease Control and Prevention, National Center for HIV. STD and TB Prevention, Divisions of HIV/AIDS Prevention. http://www.cdc.gov/hiv/aboutdhap/perb/guidance.htm

- HIV Prevention Program Evaluation Materials Database, Centers for Disease Control and Prevention, National Center for HIV, STD and TB Prevention, Divisions of HIV/AIDS Prevention. http://www.cdcnpin.org/scripts/dhap/selection.asp

- Centers for Disease Control and Prevention, MMWR, Framework for program evaluation in public health,

September 17, 1999/Vol.48/No.RR-11. http://www.cdc.gov/mmwr/preview/mmwrhtml/rr4811a1.htm

Q. *There seem to be a lot of forms to fill out. Won't this take time away from the actual work?*

A. At first it may take some time to set up forms, data collection, and reporting systems. Throughout program planning and implementation, having data systems in place will save time for both front-line staff and program managers. For example: tracking forms that are completed routinely will help staff conduct program activities efficiently; monthly activity reports will help program managers monitor program activities progress, and assess use of resources.

Examples of process monitoring, process evaluation, and outcome monitoring forms and tools are in the Community PROMISE Implementation Manual, Module 5: Evaluation. An agency staff person familiar with data management can customize the various tracking forms to fit the agency's needs. A TA provider can also provide direction in this task. Once these forms are tested and made final, program staff should be thoroughly trained on how to access, use (including correct use of each field; expected frequency of data input), and save their information. If data collection and analysis are performed throughout Community PROMISE, the program has greater chances of functioning smoothly and efficiently and achieving its goals.

Q. *We have adapted Community PROMISE to fit our target population and circumstances. How can we determine whether we are implementing with fidelity?*

A. As described above, a major objective of process evaluation is to determine if the intervention's core elements were implemented with fidelity, a requirement for implementing Community PROMISE. For a TA provider, this involves helping an implementing agency understand ways in which the intervention can—and cannot—be altered without sacrificing program effectiveness. Agencies are expected to adapt Community PROMISE to fit the needs of their specific target populations. To determine whether the intervention is being implemented with fidelity, it is necessary to review whether the four core elements and all of their various components have been included as part of the agency's planning and development of the intervention.

For example, a TA provider can assist agency staff by reviewing the plans and results of the formative research conducted as part of the CID core element. Data from the CID process should help in identifying, prioritizing, accessing, and understanding groups targeted for intervention. Information from the CID should also inform subsequent program implementation elements.

Similarly, process monitoring and process evaluation data related to the other core elements and their components can help staff assess whether processes are being conducted correctly as part of the intervention.

Below are examples of questions to measure fidelity to the four core elements:

CID Process

Did the CID process generate useful information regarding:

- The target population
- Accessing the target population
- Risk behaviors of the target population
- Goal behaviors of the target population
- Factors influencing adoption of the goal behaviors
- Stage(s) of change of the target population

Role Model Stories

Do role model stories reflect the CID findings?
Do they include the eight key components?
Do they include the appropriate range of stages of change regarding the correct behaviors?

Peer Advocates

Are they members of the target population?
Have they been trained?
Do they distribute role model stories appropriately, in accordance with the agency's distribution plan (i.e., are role model stories distributed to the target population in the methods, locations, and frequencies identified in CID process)?
How long do peer advocates continue with the program?

Evaluation

Has an evaluation plan been developed?
Are process data being collected at regular frequencies?
Are data being recorded, analyzed, and reported?

Throughout, this TA manual has included examples of how agencies adapted Community PROMISE while maintaining fidelity to the core elements. The TA provider can assist implementing agencies in determining the appropriate adaptations that meet the agency's and community's needs while also adhering to the core elements. For example, it may be appropriate for role model stories to be distributed openly in a social setting in one community, yet more appropriate to be distributed discretely in another community. Resources many permit production of glossy color stories in one agency, black and white photocopies in another. These adaptations of the intervention to the agency and community reality is expected and typical.

Q. *My agency is not required to conduct a detailed evaluation, just keep track of some basic numbers, so we don't have an evaluator. How do we handle doing outcome monitoring?*

A. If possible and if resources allow, agencies may conduct outcome monitoring to measure change in behavior, and therefore change in the stage of the majority of the target population once the intervention is implemented. This can help answer the question, "Did the expected outcomes occur?"

To conduct outcome monitoring, it is necessary to collect data about client outcomes before, during and after the intervention, such as behaviors, influencing factors, or intentions for behavior change. To accomplish this, outreach workers conduct surveys with the target population that relate to the issues in question. They may also

conduct informal interviews. These surveys and/or interviews may be incorporated into an ongoing CID process.

Questions can point to indicators that can be measured, for example:

- Use of condoms in specific circumstances
- Intention to use condoms
- Attitudes about using clean needles (or other influencing factors)
- Stage of change for use of clean needles
- Recall of role model stories (testing the ability to recount stories)

Free volunteer technical assistance providers with expertise in evaluation are available though the BSSV program of the APA. They are available in most areas to provide short-term consultation on a number of issues related to implementing or evaluating Community PROMISE.

If the agency is interested in conducting more intensive outcome monitoring and has sufficient resources, it should consider hiring an outside evaluator with the appropriate expertise. Although agency staff can adapt outcome monitoring tools that have been developed for Community PROMISE and can gather outcome data from the target population using these tools, an evaluation consultant would be valuable for several other evaluation activities. These activities are summarized below.

- **Sampling and Evaluation Design**

In most research field trails, representative samples are used to produce statistics that describe the population from which the sample was drawn. This is not the case for implementing and evaluating Community PROMISE. Think about it, how could you possibly get a representative sample of non-identified gay men or injection drug users? Note that original researchers working on Community PROMISE used convenience sampling, not representative sampling. Agencies implementing and evaluating Community PROMISE will also use convenience sampling, that is, surveying members of the target community who are conveniently contacted and agree to participate in the survey.

An example of convenience sampling is where staff stand on a selected street corner to administer the survey before the intervention (baseline), at 6-12 month intervals (follow-up) and at the end of the program (post-program). Or, snowball sampling can be used where one interviewee refers staff to the next and so on, through the peer network.

Key informants who participate in the CID can help staff strategically design the evaluation data collection procedure. It is important to administer the surveys at several strategic locations. This will allow staff to capture data on as many parts of the target population as possible. The frequency of conducting evaluation surveys will depend on agency resources and requirements of funders.

- **Data Entry, Quality Control, and Analysis**

Some of the data from the interview/ survey may be qualitative in nature (i.e., descriptive, written responses) and can be summarized by hand. However, most of the data will probably

be quantitative (i.e., check off a limited number of closed-ended responses, or the collection of numerical data) and will be more efficient to analyze if these data are entered on a computer. For agencies that do not regularly do data entry and analysis, an external consultant is recommended. As discussed in other parts of this manual, people who are proficient at working with survey/interview data can often be found in local colleges and universities, such as graduate students who may be interested in interning at your agency. When recruiting such an individual, he or she should be equipped with a computer and appropriate software for data entry and simple analysis, such as the Access program in Microsoft Windows. They also should have experience with computer procedures for checking the quality of the data to be analyzed and running similar statistical analysis on pre- and post-intervention survey data.

- **Interpretation of Findings for Assessing Progress and Program Improvement**

Once the data are analyzed, the consultant or staff member who has done the analysis should review the findings with Community PROMISE implementers. Using the agency's logic model, the findings should indicate the progress that has been made in achieving the articulated short-term and/or longer-term outcomes. As stated earlier, in that the intervention is based on Stages of Change as its theoretical framework, progress does not necessary have to reflect that the target population reduced its risk behaviors. Progress is reflected in the extent that the population has advanced to the next stage. If expected progress has not been made, staff should review results of their process monitoring and evaluation efforts to determine whether the intervention has been implemented according to design with fidelity.

Generating outcome monitoring results that are favorable and demonstrate progress is always rewarding. Results that do not demonstrate progress provide opportunities for important problem-solving among program staff. Staff can go back to the program logic model, rethink how the intervention is being implemented, and whether these efforts could be improved. Revisiting the logic model with the generated outcome monitoring data can also help staff determine whether some outcomes are unrealistic and may need to be "tweaked."

Q. *How can the Staging Instrument be used for outcome monitoring?*

A. The Staging Instrument, a tool that may be used in formal or informal interviews to help staff determine the stage of change of target population members at a given moment in time, can be used to assist agencies in outcome monitoring activities. This tool is included in Appendix C. However, Community PROMISE implementers should be careful not to administer the tool closely behind the condom distribution activity because this could skew the results.

G. Managing and Sustaining the Intervention

Once agencies have made a commitment to implement Community PROMISE, they should consider several factors that are important in effectively managing and sustaining the program. Adequate staffing is necessary to plan, implement and evaluate Community PROMISE. At the very least, this means operating with two or three staff members for major tasks. If the program is implemented in a large geographical area, such as a rural area, one outreach worker can oversee the work of approximately 10 to 15 peer advocates; in small areas an outreach worker can supervise 20 to 25 peer advocates. To assist Community PROMISE implementers, the tasks and responsibilities of paid staff have been outlined in of this manual in Section Four: Implementing Community PROMISE, and in the Community PROMISE Implementation Manual, Module 6: Management.

Another important issue in managing and sustaining the intervention concerns effective budgeting. Some components of Community PROMISE have a Good, Better, and Best option for implementation and agencies need to made decisions on these options based on the resources they have available. After the intervention is funded and implemented, agencies will need to consider how to sustain funding. In that most sources of funding—such as block grants or health departments—are earmarked for specific risk behaviors and populations that can change over time, this can present challenges for maintaining funding of Community PROMISE over time.

Effectively managing the intervention requires agency staff to work with a well-articulated plan that includes a detailed schedule of tasks that need to be implemented, the staff/volunteers who are responsible for these tasks and when they need to be completed. These tasks are summarized below and are in more detail in the Community PROMISE Implementation Manual, Module 6: Management.

- *Planning and preliminary activities* (carry out the CID process, hire and train paid staff, conduct community mobilization);
- *Intervention set-up* (recruit and interview role models, write and produce role model stories, assemble packets for distribution);
- *Establishing the outreach component* (recruit and train peer advocates, retain peer advocates, develop a distribution plan, supervise peer advocates with their distribution efforts);
- *Ongoing operations*: *role model story publication* (periodically recruit role models, write and publish stories, manage peer advocate distribution of materials, regularly document efforts);
- *Ongoing operations*: *peer advocates* (periodically recruit and train peer advocates, continue supervision of advocates, continue activities to reward and retain advocates)
- *Program evaluation* (collect evaluation data, generate and manage database, analyze and summarize data, report data)

TA providers can be helpful to Community PROMISE implementers in their efforts to manage and sustain the intervention. They can assist agency staff to develop an effective management plan and budget, help problem-solve if the implemented program diverts from the plan, and address issues related to financially sustaining the intervention over time. TA providers can also supply agencies with information about other available TA and resources to help with this effort.

This section contains information TA providers need to help Community PROMISE implementers effectively manage and sustain Community PROMISE. It includes questions and answers related to two issues that were identified during field testing:

- Effectively managing peer advocates in the field
- Effectively managing and sustaining the program

Effectively Managing Peer Advocates in the Field

Managing and retaining peer advocates can pose several challenges to agencies that are implementing Community PROMISE. As members of the target population, their lifestyles are often not stable and their living arrangements can be transient. Although advocates may have received initial training and materials to distribute in the field, outreach workers will need to maintain regular contact with them to ensure the quality of their work and supply them with additional materials for distribution. In addition, the agency will need to invest in the care and retention of their volunteers to encourage their involvement and commitment to the program. TA providers can help agencies address these challenges.

Here are some questions that Community PROMISE implementers may ask about how to effectively manage peer advocates in the field:

Q. Our peer advocates are doing a lot of work for the program. How should we reward them?

A. The care and retention of peer advocates is a labor-intensive endeavor but crucial to the success of Community PROMISE. Although research on the past implementation has shown that target population members find the novelty of being an advocate a positive experience and take a lot of pride in serving their community, it is important that specific efforts be built into the program for their care and retention. One way of rewarding advocates is through the use of incentives. In order to be effective, it is helpful to find out from advocates themselves what would be most appreciated. Several different kinds of incentives have been used in the past implementation of Community PROMISE and some of these are described below. TA providers can review these with agency staff and encourage them to get the advice of the advocates.

- *Providing small gifts (i.e., t-shirts, backpacks, coffee mugs, hygiene kits, sunglasses), cash, discount certificates, food coupons, to advocates on a regular basis.* A concrete schedule for disbursing incentive should be set up (no more than

monthly is recommended) and known to the advocates in order to maintain equity in reward distribution. To increase program recognition and promote further identification with the program, the project name and logo can be inscribed on the incentive items.

- *Providing opportunities for social gatherings of the advocates such as picnics, community barbeques, parades, and other appreciation events*. Past Community PROMISE implementers have also held events like advocate bingo and an AIDS prevention play. These events allow advocates the opportunity to bring their family members and/or guest to the event. Food and raffle prizes can be donated by local businesses that support Community PROMISE efforts in the community.

- *Providing money-generating opportunities for advocate, such as block parties, garage sales, and bake sales*. In some sites, agency staff have helped organize these events and the advocates have developed their own internal organization to run them and determine how the raised funds can be split among advocates or reinvested for further fund-raising efforts. This type of activity has allowed advocates to feel more ownership and investment in the program.

- *Sending cards and letters signed by staff members showing appreciation and acknowledging advocates for their hard work*. This can include birthday cards and written correspondence, such as when advocates are in the hospital, jail or prison and can be used for court appearances, job references and for parole officers.

- *Using other non-tangible motivators*. Regular staff attention and recognition is greatly appreciated by advocates and staff should go out of their way to interact with them, ask about their Community PROMISE work and reinforce the importance of their participation to the program.

Q. *How can we try to assure that peer advocates are doing quality work with the target population?*

A. The two major methods for assuring quality work among advocates are training and regular supervision. Training, as described earlier in this manual (see Section Four: Implementing Community PROMISE, C: Recruiting and Training Peer Advocates) gives advocates the opportunity to learn and practice the skills that are needed in doing effective distribution of role model stories and prevention materials. Training opportunities should not only be provided before the person goes out into the field but on an ongoing basis. This includes both the chance to do role plays in a "classroom" setting as well as the opportunity to observe outreach workers in the field and be observed by staff and receive useful feedback. Ongoing training can be conducted by encouraging advocates to attend regular support group meetings (weekly, bimonthly, monthly) where they can discuss the contacts

they have made and any questions or difficult interactions they may have encountered. In this type of environment, the outreach worker, as supervisor, as well as the peer advocates, can offer advice and help with solutions to these difficulties. In addition, more STD/HIV knowledge can be imparted, new program information given, and role plays can be done to allow advocates to get further feedback from their supervisors as well as other peers.

Some Community PROMISE implementers have found they needed to be creative in encouraging advocates' participation at the regular support group meetings. Some agencies have combined social events with the meetings to encourage participation or have used the meetings as a time to distribute incentives. If participation wanes, TA providers can encourage the agency to receive feedback from advocates about how meetings can be enhanced to encourage participation.

Another factor that can contribute to the quality of work of advocates is maintaining effective supervision. If the program is implemented in a large geographical area, such as a rural area, one outreach worker should not supervise more than 15 peer advocates; in smaller areas he/she should not supervise more than 25. In addition, past experience of Community PROMISE implementation has found that if the program employs more than one outreach worker, it is helpful to rotate them, preferably monthly, to supervise a different set of peer advocates. For example, Long Beach found that over time some outreach workers became proprietary about "their" peer advocates, not wanting to report contact information or even distribution figures in order to "protect" advocates' anonymity. In addition, some advocates became manipulative with the outreach workers.

Outreach workers can face several challenges with simply trying to stay in contact with advocates due to their busy lifestyles and transient nature. TA providers can make the following suggestions to outreach workers about maintaining contact with advocates:

- *Maintain records of telephone numbers and addresses.* Don't throw away old or discounted numbers; keep a record of as many numbers as possible; obtain a message phone number of a relative or friend who is in regular contact with the advocate.

- *Check advocate's hangouts.* This could be where they go to buy, sell, transfer, or use drugs, or meet clients for sexual solicitation; certain stores or restaurants they frequent; or certain phones they use to make connections.

- *Call around or visit contacts.* Visit jails, hospitals or treatment centers; contact member's of the advocate's network, other outreach workers or people who may have helpful information (parole officer, neighbor, apartment manager).

Q. *How often should an outreach worker maintain contact with advocates in the field? What kinds of information should be collected from them?*

A. An outreach worker should visit peer advocates each week in the field, preferably at agreed-upon distribution sites. The outreach worker should provide the advocate with supplementary prevention materials and discuss how past distribution efforts have gone including field conditions, target population members acceptance of the materials and their issues and preferences. Immediately after an interaction with an advocate, the outreach worker should document the content of the interaction and the materials provided.

Effectively Managing and Sustaining the Program

In addition to managing peer advocates, Community PROMISE implementers may ask TA providers to assist them with managing other aspects of their program. Because community-based organizations are often operating with meager resources, they may need help with how to best use their funds to implement Community PROMISE and sustain it. In addition, staffing issues may arise, especially when those who have been trained in the intervention leave the agency and new staff is hired. BSSV TA providers cannot assist agencies with all their needs, however, and they will need to know how to identify others who can provide more substantive assistance to the agency.

Here are some questions that Community PROMISE implementers may ask about how to manage and sustain their program:

Q. *Our agency has few resources. How can we best maximize Community PROMISE for our community?*

A. You do not need a lot of resources to implement Community PROMISE. However, as this manual (Section Four: Implementing Community PROMISE, A: Decision Making and Getting Started) and the Implementation Manual (Module 1, Introduction and Core Elements) emphasize, agencies have a financial advantage if they already have certain elements in place. These elements are summarized below.

- *Previously existing outreach component.* The heart of Community PROMISE is outreach to a specified target population and distribution of role model stories, usually accomplished through the use of peer advocates who are supervised by the agency's outreach worker(s). If the agency does not have an outreach component already in place, is will take extra time and resources to establish one.

- *Well-defined target population and access.* Community PROMISE works well and is cost-effective when implementers can focus on a specific sub-population that have specific risk behaviors and can be readily accessed. For example, even though many women in a community may be at risk, an agency may recognize that sex workers are at especially high risk

because of their specific behaviors. Further, they may realize from the CID process that sex workers have several different sub-populations and that those who work the streets in a specified location are the most accessible target population who can be readily reached.

- *Prior knowledge and experience with the target population*. The agency may realize that among the sub-populations that could be considered for the Community PROMISE intervention, agency staff have already have considerable experience with certain ones. This prior knowledge and experience is an important internal resource that would not necessitate the use of additional resources to educate existing staff.

- *Previously existing volunteer base*. A major cost-saving option for Community PROMISE is the use of peer advocates, instead of agency staff, for the mass distribution of role model stories and prevention materials and for the social marketing of the program. Having a previously existing volunteer base of target population members can be financially expedient due to the amount of time it takes an agency to establish trust in the community, connect with the target population and recruit reliable and committed volunteers.

- *Part of a strong collaborative network*. ASOs are starting to recognize that operating in isolation and having turf wars with similar organizations does not serve the needs of clients nor is it politically or financially advantageous. Rather, ASOs are beginning to develop strong collaborative networks so that multiple services are available to address their clients' needs. These networks can be highly beneficial in the marketing of Community PROMISE and in involving multiple agencies in overall implementation efforts and cost-sharing.

- *Existing technical skills and technology*. The role model stories can be produced at a small cost when an agency has existing staff who are artistically or technically skilled in the use of computer graphics software that the agency has already purchased.

Q. *How do we access technical assistance to help us implement Community PROMISE effectively?*

A. The role of a BSSV TA provider is to problem-solve with Community PROMISE implementers, provide technical advice, and identify additional resources that can be helpful. If an agency does not have the internal staff capacity to implement certain parts of Community PROMISE with fidelity, the BSSV TA provider can assist the agency with finding the appropriate resources. This can include qualified individuals who can train existing staff, existing tutorials and resources on the internet (e.g., how to run focus groups, how to use computer graphics software), or qualified individuals who can provide direct hands-on help.

Often, the most cost-effective approach is to identify interested graduate students at local universities who may be technically competent and quite interested in working with a community-based organization. If resources allow, you may want to consider employing a consultant. Whoever you may find to help, whether they are volunteers, paid interns, or consultants, it will be helpful if they have a background in STD/HIV prevention and past experience and respect for the target population. Other specific qualifications that are needed for implementing specific tasks on Community PROMISE have been summarized in the Implementation Manual, Module 6: Management, and should be reviewed in order to recruit appropriate individuals.

Q. *How should we handle staff turnover during the implementation of Community PROMISE? How can new staff become oriented and trained?*

A. Because staff turnover is not uncommon, all prospective Community PROMISE implementers should try to send more than one staff member to formal trainings so that knowledge and skills can be diffused back to the larger agency and transferred to new staff members who may be hired at a later date. New staff should receive a copy of the Community PROMISE Implementation Manual and previously trained staff should review the manual with them, as well as review how the agency has adapted and tailored Community PROMISE to the target community, and what specific role(s) new staff will have on the intervention. In addition, the agency should find out where the next Course Two training is taking place and try to send new staff to it.

Q. *Our funding for Community PROMISE will be ending soon and we will have to operate with considerably less funds. How can we try to sustain the intervention over time?*

A. TA providers can offer several suggestions to Community PROMISE implementers related to sustaining the intervention when funding ends. Most importantly, agencies should be encouraged to look for additional funds. Funders are considerably more inclined to fund an intervention, like Community PROMISE, that is science-based. If implementers are also able to provide evidence of how it has benefited the local target population, this can also make a proposal more convincing.

Agencies can sustain the intervention if they are able to identify places where costs can be cut. Strengthening the volunteer base is certainly one way to do this, as is collaborating with other agencies to carry out the program and share costs. If Community PROMISE implementers have used considerable resources in the production of role model stories in the past, they may want to identify more cost-effective options. Surprisingly, when past implementers have scaled down the "look" of their publications to the low-cost black and white photocopy option they found that the target population was equally satisfied. If the publications have successfully "hooked" the target population on the content of the stories and its characters, people will be less concerned with what the publication looks like and more interested in what it says.

If Community PROMISE has been well diffused in the community, and has involved local merchants and vendors, a threat to its sustainability may generate concern and willingness to financially assist, even in small ways. Past Community PROMISE implementers, for example, found that when a printing vendor was told that the agency could no longer afford printing costs, the vendor was quite willing to lower costs in order to sustain the intervention.

Appendices

Appendix A: Resources

American Psychological Association Behavioral and Social Science Volunteer Program *www.apa.org/pi/aids/bssv.html*

California AIDS Clearinghouse www.aidsinfo.org

Compendium of HIV Prevention Interventions with Evidence of Effectiveness *http://www.cdc.gov/hiv/pubs/hivcompendium/hivcompendium.htm*

Dallas Prevention Training Center, The University of Texas Southwestern Medical Center at Dallas *http://www2.utsouthwestern.edu/cpiu/preventiontrainingcenter.htm*

Denver Prevention Training Center and the Denver Public Health Department http://www.denverptc.org

Diffusion of Effective Behavioral Interventions for HIV Prevention, Academy for Educational Development *http://www.effectiveinterventions.org*

Divisions of HIV/AIDS Prevention, National Center for HIV, STD and TB Prevention, Centers for Disease Control and Prevention *http://www.cdc.gov/hiv/dhap.htm*

National Network of STD/HIV Prevention Training Centers *http://www.cdc.gov/nchstp/dstd*

National Prevention Information Network, Centers for Disease Control and Prevention *http://www.cdcnpin.org*

New York State STD/HIV Prevention Training Center, Center for Health and Behavioral Training *http://depts.washington.edu/nnptc/regional_centers/nysptc/about/aboutbt.html*

Replicating Effective Programs Plus, Centers for Disease Control and Prevention *http://www.cdc.gov/hiv/projects/rep/*

Appendix B: Implementation Steps

Planning and Preliminary Activities *(Social mobilization, the CID process, recruitment and training of staff)*

Task	Capacity and Knowledge Needed	Notes
Market intervention to stakeholders	Knowledge of intervention; marketing skills; ability to answer questions	
Network with other agencies and community organizations	Knowledge of intervention; marketing skills; ability to answer questions; knowledge of community and agencies that affect your community	
Form a community advisory board	Knowledge of intervention; marketing skills; ability to answer questions; ability to establish connections with community persons	
Prepare for the CID process: gather and refine or adapt the necessary materials: interviews, key participant interview, community observation protocol, focus group script and materials, informed consent, field safety guidelines	Questionnaire/interview development skills	
Recruit, hire, and train interviewers (may be future implementation staff).	Detailed knowledge of interviewing skills and the various interview protocols to be used; training and supervisory skills; ability to relate to target population	
Survey internal staff	Knowledge of people in your own organization who interact professionally with target population; ability to establish trust; interviewing skills	
Survey external sources of information	Knowledge of people who interact professionally with target population; ability to access them, create trust and elicit information; ability to explain your purpose; interviewing skills	

Planning and Preliminary Activities *(continued)*

Task	Capacity and Knowledge Needed	Notes
Conduct gatekeeper interviews	Street knowledge; ability to interact with strangers, create trust, and elicit information; ability to explain your purpose	
Conduct key participant interviews	Street knowledge; ability to interact with strangers, create trust, and elicit information; ability to explain your purpose	
Conduct community observations	Street knowledge; ability to interact with strangers, create trust, and elicit information; ability to explain your purpose; detail-oriented; observant	
Conduct focus groups	Experienced at conducting focus groups (not therapy groups); group facilitation skills	
Debrief staff using open-ended questions; assist staff in differentiating between inferences, assumptions, and observations. Assemble data and prepare comprehensive report about the target population	Skills in staff debriefing, qualitative data-analysis, writing, and group facilitation	
Make final decision regarding target population	Knowledge of intervention and agency; understanding of agency's priorities and mission; knowledge of CID results to determine target population's need, stage of change, and influencing factors	
Decide on target behavior	Knowledge of intervention and agency; understanding of organization and funding agency's priorities and mission; knowledge of CID results to determine target population's need, stage of change, and influencing factors	

Task	Capacity and Knowledge Needed	Notes
Recruit and hire outreach workers and other program staff	Knowledge of intervention and of outreach activities and type of personnel needed	
Train outreach and other staff. Training issues include safety, conducting outreach, documentation, and the intervention	Experienced in outreach, ability to engage target population; knowledgeable and committed to the intervention; knowledge of tasks required to implement Community PROMISE and forms to conduct evaluation; group facilitation skills	
Select specific sites and means of accessing target population	Knowledge of sites frequented by target population; ability to access them; ability to establish trust with sites	
Contact (through surveys or focus groups) community advisory group and some members of the target population to identify preferred program name and materials (e.g., number and/or types of condoms, in packs, format of role model stories, use of photos versus drawings, etc.)	Street knowledge; ability to interact with strangers; ability to create trust and elicit information; ability to conduct focus groups and process results	
Prepare and train staff on the necessary Community PROMISE forms and procedures for implementation in your agency and community	Form-development skills; knowledge of the intervention	

Intervention Set-up

(Recruit, screen, and interview role models; write role model stories; pre-test and produce role model story publications)

Task	Capacity and Knowledge Needed	Notes
Recruit potential role model	Knowledge of intervention, target population, and type of behavior and stage of change needed; skills to explain the program and purposes of story	
Screen potential role model	Knowledge of intervention, target population, and type of behavior and stage of change needed; skills to explain the program and purposes of story	
Interview role model for story	Interviewing skills; familiarity with special interview format (transcriber) if interviews are taped	
Write role model story from transcript or interview notes and edit it after reviewing for eight key elements	Knowledge of theory; practiced at writing role model stories and using role model story worksheet; good understanding of purpose and intent of role model stories; writing skills	
Decide on size of publication	Knowledge of target population preferences; knowledge of agency resources	
Decide type of paper and colors for the publication	Knowledge of target population preferences; knowledge of agency resources	
Decide on artwork: photographs (identify models and photographer) or drawings (identify artist)	Knowledge of local resources and target population preferences; ability to communicate what is needed from photographer or artist	
Develop mock-ups of role model story publications	Graphic design skills	

Task	Capacity and Knowledge Needed	Notes
Locate printer or identify method of in-house publication of materials	Knowledge of local resources; ability to negotiate best price	
Pre-test with the advisory board: the mock-up, the role model story itself, and the program name	Familiarity with form developed for purpose; ability to describe purpose and theory behind intervention; ability to manage the group process or individual meeting; group facilitation skills	
Pre-test with members of the target population: the mock-up, the role model story itself, and the program name	Familiarity with form developed for purpose; street knowledge; access to target population; ability to manage a focus group process if one is done; group facilitation skills	
Revise story as necessary	Knowledge of theory; practiced at writing role model stories and using role model story worksheet; good understanding of purpose and intent of role model stories; writing skills	
Identify other information to be contained in publication (e.g., referrals, ads, coupons, credit for support)	Knowledge of community as well as needs and interests of target population	
Prepare and publish approved version of publication.	Careful attention to detail; good proof-reading skills	
Assemble first kits to be distributed (e.g., role model publication, condoms, condom information)	Ability to direct and support clerical staff or peer advocates in assembling materials	

Establishing Outreach Component

(Recruit and train peer advocates; map geographic distribution plan; establish advocate materials distribution schedule; plan peer advocate appreciate activity; conduct ongoing production of role model stories; develop material distribution packets for advocates)

Task	Capacity and Knowledge Needed	Notes
Recruit peer advocates by establishing community presence, identifying recruitment contacts or areas, initiating recruitment, and engaging in follow-up activities. Recruit to cover social networks. Invite potential advocates to Community PROMISE training	Street knowledge and comfort in the community; access to target population and ability to engage the target population; skills to explain the program and the peer advocates role in a way that makes it attractive to the potential advocate	
Identify and pre-test peer advocate incentives	Comfort with target population; knowledgeable about peer advocates' needs and preferences	
Conduct peer advocate training. Invite selected persons to become peer advocates and others to be community observers. Provide advocates with initial materials and assign outreach worker	Training skills; comfort with population; ability to thoroughly explain the intervention and the advocates' role	
Outline geographical area on a local map where materials distribution is to occur; place dot where each advocate works; recruit additional advocates to fill in gaps. Be aware of appropriate number of advocates to cover existing social networks	Knowledge of geographic area; familiarity with peer advocates and their social networks and areas of operation	
Outreach workers establish weekly peer advocate visiting schedule. Provide peer advocates with new materials. Document materials distributed by peers	Friendliness, comfort with target population; knowledge of how to use forms; knowledge of Community PROMISE	
Plan and implement periodic peer advocate appreciation activity (e.g., block party, special gifts, movie night)	Friendliness, comfort with target population; knowledgeable about peer advocates' needs and preferences	

Ongoing Operations for Role Model Stories

(Recruit and interview role models; write, publish, and disseminate stories)

Task	Capacity and Knowledge Needed	Notes
Recruit role models periodically	Knowledge of intervention, target population, and behavior and stage of change needed; verbal skills sufficient to explain the program, making it attractive to the potential advocates	
Interview role model for stories	Interviewing skills; familiarity with special interview format (transcriber) if the interview was taped	
Write role model story (one or more) from transcript	Knowledge of theory; practiced at writing role model stories using worksheet; good understanding of purpose, intent of role model stories; writing skills	
Publish the role model story		
Pre-test all of the first five role model stories, then every fourth one, with at least 12 target population members	Familiarity with form developed for purpose; must be able to describe purpose, theory behind intervention; ability to engage target population; ability to ask open-ended questions	
Revise role model stories as needed	Knowledge of theory; practiced at writing role model stories using worksheet; good understanding of purpose, intent of role model stories; writing skills	
Design and paste up each role model story publication	Graphic design skills	
Reproduce each role model story publication in sufficient quantity	Knowledge of agency's resources and distribution needs	
Package role model story with appropriate materials (e.g., condoms, condom instructions, plastic bags)	Ability to direct and supervise clerical staff or peer advocates in assembling materials	
Distribute materials to peer advocates, documenting numbers and dates when distributed	Knowledge of documentation requirements; ability to engage advocates and maintain their interest; ability to explain the intervention and provide on-going training to advocates as needed	

Ongoing Operations for Peer Advocates

(Recruit, train, supervise in the field; disburse incentives and other appreciation activities)

Task	Capacity and Knowledge Needed	Notes
Recruit peer advocates periodically Conduct peer advocate training.	Street knowledge; access to target population; ability to engage target population; comfort in the community	
Invite additional persons to become peer advocates and others to be community observers. Provide advocates with initial materials and assign outreach workers	Training skills; comfort with population; ability to thoroughly explain the intervention and the advocates' role; group facilitation skills	
Visit peer advocates regularly in the field. Provide with supplementary materials, inquire about acceptance, field conditions, target population issues and preferences. Immediately following the interaction, document the content of the interaction and materials provided	Ability to maintain positive relationship with peer advocates and elicit their cooperation; knowledge of documentation forms	
Provide incentives (e.g., hygiene kits, baseball caps): annually poll peer advocates regarding what small gifts they would like as incentives for volunteering. Give them a choice of items the program can afford	Friendliness, comfort with target population; knowledge of peer advocates' needs and preferences; creativity	
Give peer advocates an appreciation party annually at a time convenient for them and you. Include food, certificates of appreciation, raffle, small door prizes or gifts, games, music, entertainment if possible	Friendliness, comfort with target population; knowledge of peer advocates' needs and preferences	
Hold social gatherings, with cards and gifts for advocates	Friendliness, comfort with target population; knowledge of peer advocates' needs and preferences	

Evaluation

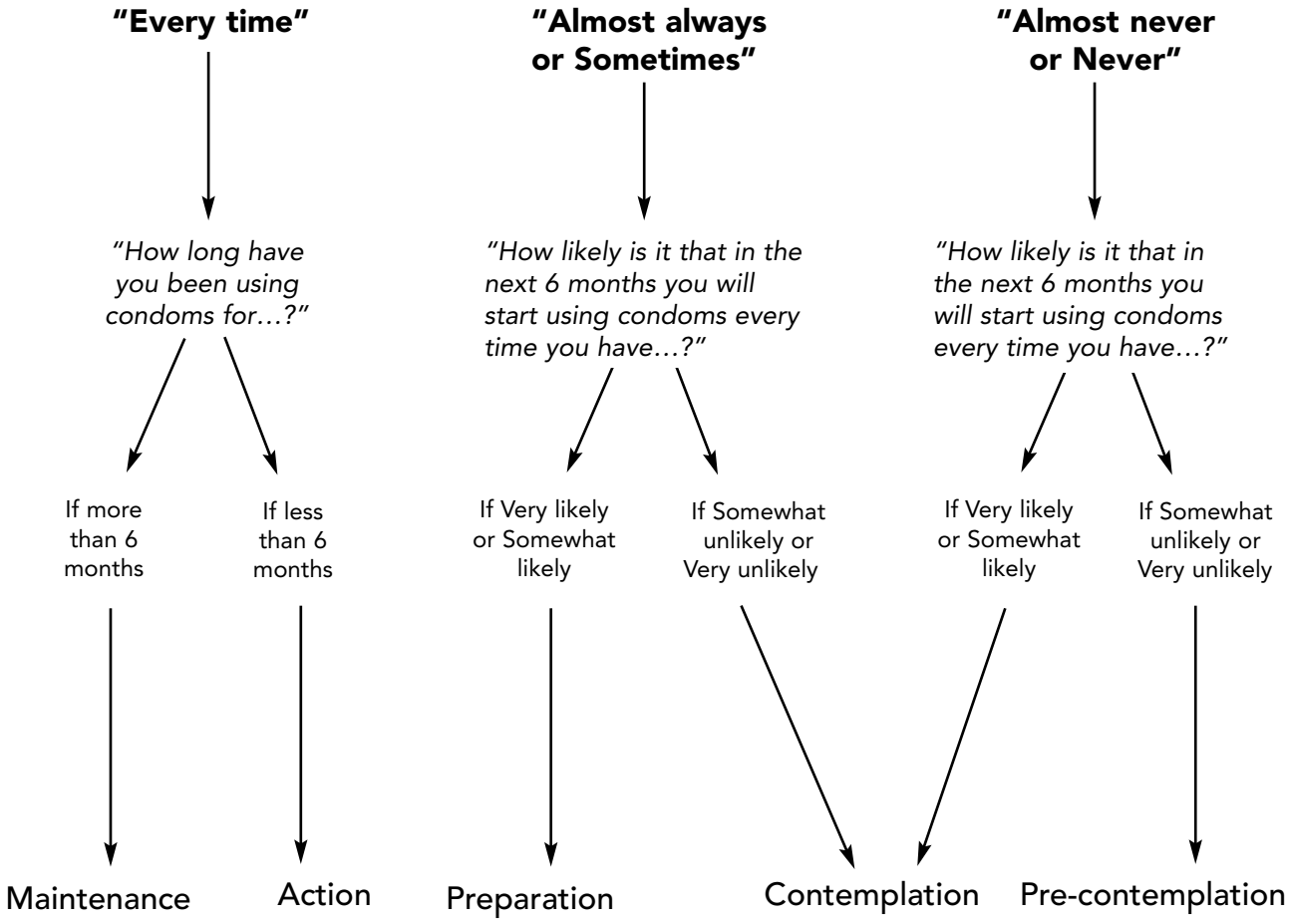
(Collect data; create database; manage, analyze, and report data)

Task	Capacity and Knowledge Needed	Notes
Collect necessary evaluation forms	Knowledge of Community PROMISE evaluation forms, purpose, intent, and usage; instrument design experience; ability to motivate staff to complete forms; ability to communicate need for evaluation to staff	
Generate database for data collected; manage database	Knowledge of data management techniques and software (e.g., Microsoft Access, Microsoft Excel, SPSS, SAS)	
Summarize data from evaluation forms	Ability to use basic commands for aggregating and reporting data	
Analyze and report collected data	Knowledge of analysis techniques; knowledge about how organization and funding agency defines success	

Appendix C: Identifying Stages of Change

Target Risk-Reduction Behavior:
USING CONDOMS FOR ANAL SEX WITH PAYING PARTNERS*

"How often would you say you use condoms for…?"



**This example uses "anal sex with paying partners" as an example. Substitute the goal behavior you are measuring, such as "vaginal sex with your main partner," "oral sex with casual partners," etc.*